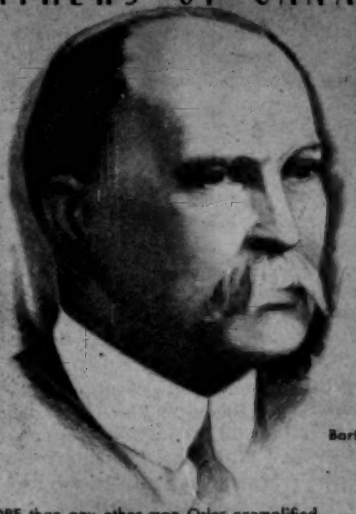
# FATHERS OF CANADIAN MEDICINE

★ONE OF A SERIES



## *Sir William Osler*

Bart, M.D., D.C.L., LL.D., D.Sc., F.R.S., F.R.C.P.
1849-1919

MORE than any other man Osler exemplified all that was best in the tradition and practice of medicine. One of nine children, he was born in 1849 at Bond Head, Ontario, and obtained his professional education at Toronto and McGill Universities. In those early days students assisted a practising physician while at college. Osler's preceptor was Dr. James Bovell, a country practitioner of broad culture.

After studying abroad, Osler was given the Chair in Medicine at McGill University. Later, he was appointed professor of clinical medicine in the University of Pennsylvania; Gulstonian lecturer at the Royal College of Physicians, London; professor of medicine at Johns Hopkins University; and regius professor of medicine at Oxford.

His contribution to the profession of medicine was outstanding. To him is attributed the adoption of bedside teaching and the system of internship which afforded students an opportunity to obtain practical experience before engaging in practice.

Osler's text-book "The Principles and Practice of Medicine" was so clear, concise and comprehensive that is was adopted as the standard text-book of medicine by all English-speaking universities. It has been revised and expanded on a number of occasions. While at McGill, he published the "Pathology Reports" which were the first of the kind in America.

Osler was unselfish even to effacement. The generosity of his hospitality was open-hearted and his entertainment of guests delightful. He had a richly endowed mind. His name will live not only because of his great contribution to medicine but also because of his "little nameless unremembered acts of kindness and love." He was known and beloved in America, Great Britain and the Dominions.

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# Reader's Guide

It is not often that any nurse is president of a provincial association and at the same time is an executive officer of the Canadian Nurses Association. This unique role is carried by our guest editor this month, **H. Evelyn Mallory, B.Sc.** A graduate of the Winnipeg General Hospital and of Columbia University, New York, Miss Mallory has had wide experience in nursing as instructor, superintendent of nurses, provincial registrar and adviser to schools of nursing. Her present work as associate professor in the Department of Nursing and Health at the University of British Columbia is largely concerned with the instruction of budding teachers and supervisors for our schools of nursing. From the vantage point of her intimate knowledge of provincial and national nursing affairs, Miss Mallory's call to action carried the weight of her deep insight into our professional needs. Let us not let her challenge go unheeded.

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The extreme care that is taken for the preservation of all the patients' records in a large hospital will come as a revelation to many of us as we read the description of the procedures followed in the filing of hospital medical records by **Frederick J. Fish.** Mr. Fish is director of the Medical Records Department at the Vancouver General Hospital. Though most of the larger institutions will have a records clerk, it frequently falls to the superintendent of nurses to supervise the disposition of the accumulated patients' charts. The detailed procedure need not be burdensome if the pattern Mr. Fish has laid down for us is followed.

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Last October, Barbara Beattie, in her guest editorial, hinted at the new developments in employment policies for nurse personnel in Alberta hospitals. We are glad to be able to present the picture which **Elizabeth B. Rogers** has prepared outlining the accepted details. It presages a new deal for general staff nurses and sets a pattern for other provinces.

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The Denis-Browne splint is now being widely used for the correction of club feet, replacing the old technique of repeated plaster casts. **Erma R. Erskine's** illustrated description will help those who are not familiar with the new procedure to understand the various steps. Miss Erskine is superintendent of nurses at the Crippled Children's Hospital in Vancouver.

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There is considerable evidence of the lasting damage caused by the emotional shock of a child's fear-provoking experience with strange people, places, objects and events. Some of this damage is inevitable but a great deal of it can be avoided by intelligent handling. **Jessie Cochrane,** supervisor of the out-patient department at the Children's Memorial Hospital, Montreal, shows us how planned effort can eliminate the unconscious cruelty frequently associated with the hospitalization of children.

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**Helen A. Saunders, B.A.Sc.,** was second prize winner in our 1945 article contest. Recently released from the R.C.A.M.C., Miss Saunders has been taking a post-graduate course in operating-room technique.

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**Clare Franckum** is with the Medical Department of the Protestant School Board in Montreal. **Mrs. Josephine Montemeuro** is nursing at the Mineral Springs Hospital at Banff.

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We are pleased to welcome a new contributor who promises us regular releases on the activities of her department. **Agnes J. Macleod, R.R.C.,** Matron-in-Chief in the Department of Veterans Affairs, is anxious that all of the nurses in Canada should become familiar with the various branches of the remedial program for our veterans. This month she has outlined the revised salary schedules for the various categories. The account by **Anna C. McArthur,** nurse-in-charge, of the work being carried on in one of the units, Scarborough Hall, Toronto, gives some inkling into the breadth of the rehabilitation program now being carried. Watch for the further items on the work of the nurses in D.V.A. hospitals.

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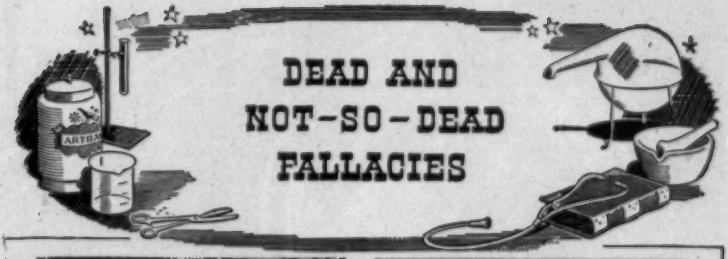
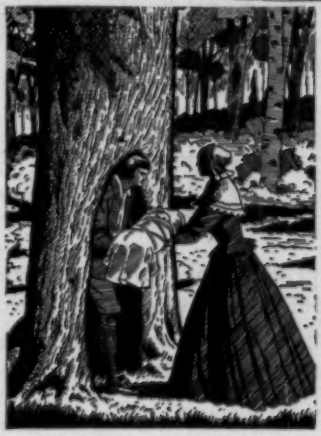


# DEAD AND NOT-SO-DEAD FALLACIES



**A CHILD** afflicted with hernia, claimed the old-time "sympathetic" healers, should be passed through the cleft in an ash tree and the hernia would then disappear. This method boasted many "cures," for, as you know, umbilical hernias in babies often tend to heal themselves.

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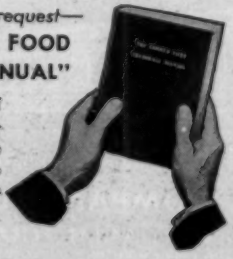

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REFERENCES — 1 West. J. Surg. & Gyn., 51:150, April, 1943. 2 Clin. Med. & Surg., 46:327, August, 1939. 3 Med. Rec., 155: 318, 1942. 4 Crossen, H.S. and R. J.: Diseases of Women, C. V. Mosby Co., St. Louis, 9th ed., 1941.

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*The special advantages in obstetrics*

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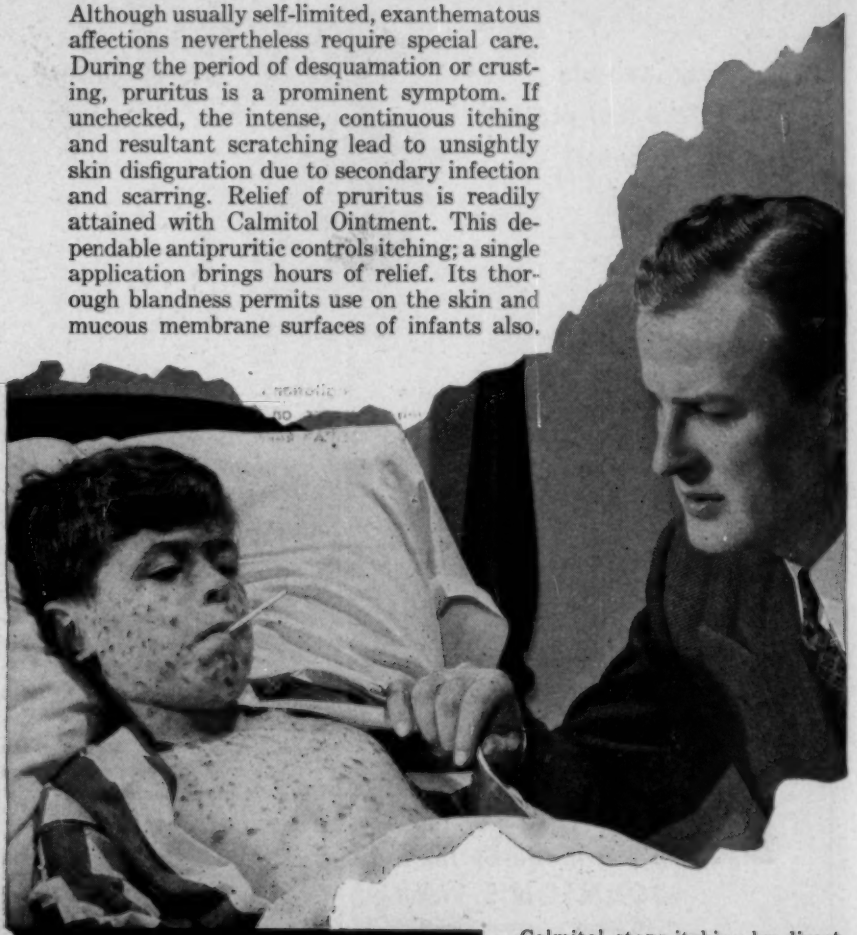

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*Wakeley, C.P.G., (1942) *The Practitioner* 149, 50

This quotation summarises a view that has been repeated in numerous technical reports, scientific papers and textbooks during the past ten years. The reason is worth considering.

It is *not* that 'Dettol' is unique with respect to any single quality regarded as essential, or at least desirable, in antiseptic substances. Thus, it is not alone in being lethal to a diversity of pathogenic bacteria, including *Strep. pyogenes, Staph. aureus, Bact. typhosum* and *Bact. coli*; indeed, tested against these organisms, some antiseptics have higher phenol coefficients. Several substances are available which, like 'Dettol', retain high bactericidal potency in the presence of blood, pus and wound contaminants: some which are non-toxic, even at full bactericidal strength: or are applicable, without causing pain or injury, to raw wounds and surfaces: or do not inhibit the natural processes of repair: or are stable at all clinically desirable temperatures and at all dilutions: or are non-staining, agreeable in use and pleasant to smell.

What *is* special to 'Dettol' is that it combines in very high measure *all* these qualities of an ideal general-purposes antiseptic, and it is to this remarkable combination of properties that 'Dettol' owes its present position as the antiseptic favoured above all others in operating theatres, labour wards, casualty posts, factories and homes throughout the Empire.

For the general practitioner and surgeon, obstetrician and nurse, patient and carrier: for sterilization of the skin, wounds or instruments: for all the contingencies of practice that call for an antiseptic that is effective and safe: for major surgery or minor mishaps—the antiseptic of choice is 'Dettol'.

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The 1946 Spring examinations for provincial registration will cover two groups of candidates and will be held as follows:
GROUP A: Graduates qualifying for the R.N. certificate will write in Montreal, Quebec, and Sherbrooke on **April 22, 23, and 24, 1946.**
GROUP B: Students who will have completed their first year before March 31, 1946, will enter the preliminary test covering oral, practical and written, which will be held on **April 8, 9, 10, and 11, 1946.**

For application forms and all information relating to the examinations apply to the headquarters of the Association.

**Applications Must Be Received Before March 31, 1946.**

**E. FRANCES UPTON, R. N.**
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To take place on May 15, 16, and 17, 1946, at Halifax, Yarmouth, Amherst, Sydney, and Antigonish. Requests for application forms should be made at once, and forms MUST BE returned to the Registrar by April 15, together with: (1) Birth Certificate; (2) Provincial Grade XI Pass Certificate; (3) Diploma of School of Nursing; (4) Fee of $10.00.

No undergraduate may write unless he or she has passed successfully all final School of Nursing examinations, and is within six weeks of completion of the course of nursing.

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**The Registered Nurses' Association of Nova Scotia**
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A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-TWO NUMBER THREE

MARCH 1946

# The Time for Action is Now

"We do not have to revert to the Middle Ages to learn that a world that has tumbled down is full of tragedy, and a world in process of rebuilding is full of opportunity for those possessed of foresight, preparation, and constructive talent."*

For the second time within the lives of many Canadian nurses this truth is being demonstrated! Those of us who have stayed at home find it difficult, almost impossible, to realize how complete has been the "tumbling down", how utter the devastation in other parts of the world. Because we have been spared so much, perhaps we think that life can go on as before—that since the war *is* over we can revert to our former way of life. We tell ourselves that we have worked hard during the last few years trying to keep civilian services going and to meet the nursing needs of war; but the war is *over* and the danger is passed now, surely we have earned the right to relax a little! Whether or not that right has been earned is perhaps a moot question, especially when we read in the press or hear over the radio descriptions of conditions elsewhere, or when at the occasional "movie" we get a brief glimpse of horrors that make us shudder and turn away, sick inside!

Far a number of years now, the Canadian people have been very patient with us. We have been unable to meet their needs for nursing service, either in quantity or quality. But there was always the answer, "There is a war on!" They accepted that answer, readily understood that the needs of the services must come first, and made the best of conditions that were often very far from satisfactory.

We went to the Dominion Government and we said: "It is because of the needs of war that we have not enough nurses. It is because of the war that civilian services are being depleted.

*Jamieson, E. M., and Sewall, Mary: "Trends in Nursing History", W. B. Saunders Co. 1944.

This is a war emergency. We must have help." Help was given, but the war is over and that financial assistance, granted for the purpose of increasing the number of nurses, was a wartime emergency measure only, and is now being withdrawn. Nurses from the three Services are being demobilized rapidly. We can no longer say that military needs are depleting the civilian service.

Yet the shortage of nurses seems more acute than ever! Of course we can quite readily explain this shortage—the reasons are fairly obvious! The demand for nursing service has expanded: all over the country hospitals are increasing their bed capacity, and new hospitals are being built; the public is becoming much more conscious of the value of health and taking the attitude that health services should be available to all people rather than to just the privileged few—but the expansion of health services is delayed partly because of the lack of public health nurses. As the men return from overseas, some of them aggravate further an already difficult situation by marrying and taking out of circulation much needed nurses. Or perhaps they are already married and their wives are nurses who now feel that husbands and homes have prior claim on them. Returned Nursing Sisters, who were expected to ease the situation, are taking advantage of educational opportunities provided by the Government in order to better prepare themselves for a community service—and why not?—it is partly for this purpose that such grants are made.

All this sounds perfectly clear and reasonable to us, and no doubt it is, but the public is getting a little impatient. They say, in effect: "You told us we could not get nurses because of the war. We believed you and made the best of it, but the war is over now, and conditions seem no better. What are you going to do about it?"

What *are* we going to do about it? One thing we can be sure of: If we do not face the situation now and soon find means to provide to the community nursing service that is adequate in both quality and quantity, the problem may be taken out of our hands and solved in a manner not to our liking.

Much of the private duty nursing in homes is already being done by the "practical nurse," (when she can be obtained) because professional nurses are not available. For years we have been talking about the "problem of the practical nurse." Is there a need for her? What should be her duties and responsibilities? Where and how should she be trained? And while we discuss the problem, lay groups initiate courses for the training of practical nurses!

During the war years school of nursing facilities have been strained almost to the breaking point with educational needs compromised in the interests of nursing service. Student nurses were obliged to assume a greater responsibility for the nursing service needs of hospitals. Enrolment in the schools was increased often beyond the number that could be provided with a sound educational experience in all essential services. These, and other measures taken, did help to some extent to meet the needs for nursing service during a period of emergency, but still there were not nearly enough nurses. What are we going to do now? Are we going to continue to compromise, to muddle along with nursing education and nursing service hopelessly confused, not only in the minds of the public but in the minds of nurses as well, as has been the case for years? Or are we at long last going to do some really constructive planning in relation to the preparation of professional nurses, frankly recognizing that we must have more nurses and better nurses if the needs of the community are to be met?

The small child shatters very quickly his house of blocks, but to build it up again requires infinitely more time, patience, and skill. Though the war gave

rise to many problems for the nursing profession, those created by a world "in the process of rebuilding" are going to be infinitely more difficult. There will be no glamour, and no awareness of a common danger to unite us. There is challenge and tremendous opportunity for professional nursing, opportunity greater than ever before—and tasks more difficult. We must plan carefully, very carefully, and we must surely build sound structures. But the time for action is now!

H. Evelyn Mallory
*President*
*Registered Nurses' Association of British Columbia*

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# Filing Hospital Medical Records

Frederick J. Fish

Should any who peruse this article do so with the feeling that it is coloured by "local" influence, let me disarm them by admitting it. How could it be otherwise considering the variances between Provincial Hospital Acts, Hospital By-laws, and local custom? As much as possible, however, the article has been written on general lines. Furthermore, in the hope of making it as useful as possible, the author consulted Miss Elizabeth Braund of the Registered Nurses' Association of British Columbia, who, with her province-wide experience through the Placement Service, brought to light several points upon which those in charge of small hospitals would welcome opinions.

## Foreword

Some twenty-five years ago the American College of Surgeons evolved a plan for raising and maintaining the standard of hospital work by defining certain procedures. The degree in which a hospital observed these would constitute a basis whereby it would receive the approval of and a classified rating by the College. That the plan was basically sound has been shown, not only in the vast improvement in treatment in hospitals everywhere, but in the fact, also, that no hospital of any size considers itself properly established without having been accorded its standard rating. Among the procedures defined by the College was included Medical Records, it being considered that no hospital could operate to the full advantage of its patients without some effort to instal and maintain a satisfactory system whereby all medical work was properly recorded and tabulated. Today no administrator, thoughtful for the welfare of his hospital, would think of ignoring this important phase of hospital activity, nor could he hope for its approval and rating.

The following remarks on hospital records are based on usage at the Vancouver General Hospital, that being mainly the scene of the writer's experience. While some of the procedures set down might not be universally applicable, the general scheme, with some modifications, would serve as a useful basis for the Medical Records Department of any hospital.

The question is often asked "Are hospitals required by law to keep medical records of individual patients?" In British Columbia, the Hospitals Act does not make this demand on either public or private hospitals. Nevertheless, the need for such is implicit in the demands

made by civic, Provincial, and Dominion Governments for information of various kinds. But even if this were not so, there still exists the necessity of providing our administrators with the means whereby they may give an account of their stewardship and last, but not least in importance, our moral responsibility as a hospital to the patient and to the medical profession.

Both individually and collectively, Medical Records are of extreme value. Too much care cannot be exercised in their compilation, safe storage, and ready access.

## The Medical Record

A patient's medical record, to suit all purposes, is best kept in dual form:

1. A card on which are recorded all personal and domestic items of information, with a brief summarization of medical data.
2. A ward chart giving minutely all information on the illness, treatment, and end result.

The medical record has its inception at the desk of the Admitting Officer where the name is taken and the case assigned a number on the hospital register. While these are the primary essentials, certain other personal items are also necessary as may be seen by reference to government and other report forms. These should be recorded, as far as possible, at the time of the patient's admission. If the dual system is to be satisfactorily maintained and the Records Department function properly, the *name* and the *number* must thereafter be inseparable. It follows that there will be a dual method of filing—alphabetical and numerical.

For the *alphabetical* system the card, being more easily handled, is a better medium than the chart. Properly completed, it frequently gives enough information to obviate the need for reference to the chart. Moreover, many more cards can be stored in a smaller space, and can, therefore, be kept readily to hand. Charts require more space and frequently find storage room in the basement or some equally inaccessible spot. A safeguard against the results of loss of cards can be provided by an indestructible loose-leaf index book, completed yearly, with the names in strict alphabetical sequence, giving the hospital number and the dates of admission and discharge (or death). Thus, if a card should be mislaid or lost, there still remains a quick and certain means of access to the chart record.

The charts become the *numerical* record upon discharge of the patient. Each chart should be placed in an individual envelope or folder with the patient's hospital number and name written in pencil on the outside. They are filed in order of admission number. Later, for convenience, they can be removed from the envelopes and bound in volumes of fifty or more. The pencilled entries on the envelopes are erased and the envelopes can be used again. Should a patient stay so long in the hospital that the chart cannot be bound in its proper numerical sequence, it should be placed, along with all such "long-stay" charts, in a separate volume and suitably cross-indexed.

*Value of records*: Records may become voluminous and any such should be given special consideration. Two methods are suggested:

1. The "Summarized" form of Nurses' Notes which, instead of being an open sheet, is ruled with spaces for fourteen days so that none but very limited remarks can be recorded. This form, used in chronic cases, should be employed only with the consent of the attending doctor. A part of the daily record on this form could cover the temperature, pulse and respirations, thus at the same time obviating use of the clinical sheet.

2. Even in cases in which the "Summarized" form has been used, a chart may still assume large proportions. The

suggestion here is that some competent person, probably the head nurse or supervisor, should, with the doctor's consent, summarize the entire nursing record, carefully recording any special circumstance, and sign the sheet. This summary is then filed with the rest of the chart while the originals are filed apart and retained for at least one year in order that they may be available if, for any reason, suit for damage should be instituted against the hospital or the doctor.

The reason one year is mentioned is that the B.C. Hospitals Act provides that no such action can be brought later than one year after the "cause for action." But while this appears to afford definite protection, legal opinion goes so far as to suggest that the term "cause for action" might be interpreted as being the date at which a long-delayed manifestation of mistaken or erroneous treatment was administered. However, for all ordinary purposes, especially where no suggestion exists of untoward results, all bulky charts might well be summarized to save valuable space.

The fact that we file and store our Medical Records makes it obvious that they have some future value. This usefulness is both individual and collective.

1. *Individual*: Their primary value is, of course, in the picture they present day-to-day to the doctor in charge of the case while the patient is in hospital. The Records Department, however, is not concerned with that aspect but rather with what information their contents can later provide in various matters affecting the patient, the doctor, or the hospital. Among other things may be mentioned the following:

Information on previous illnesses and operations; settlement of insurance claims for sickness or death; war and other pensions; workmen's compensation board; registration of birth; registration of death; legal suits; complaints; enquiries of various types by friends, relatives, and others; case studies by student nurses.

2. *Collective*: Statistical information to the hospital administration; review and research by the medical profession; government returns and statistics.

No one item on these lists can be said to have more importance than another. A good Records Department functions without bias, and treats all legitimate seekers for information with the same disinterested respect.

*Checking and tabulation of information*: To facilitate research and review work as well as to provide medical statistics, it is customary in most hospitals to tabulate certain medical information. This is especially referable to diagnoses and operations, and for this the card is the most convenient means; the appropriate entries should be compared with those on the chart. Divergencies should be investigated.

There is, however, a primary question —is the chart in good order? Whatever the nature of the case — surgical, medical, or any other—it is comprised of a varying number of forms, each for a specific purpose and, collectively, a minute record of the case. As it is possible that these loose forms may become separated and mislaid, it is very important that, in their designing and printing, provision be made, not only for the specific medical or nursing information, but also for the patient's name, that of the attending doctor, and for the hospital register number. Thus any detached sheet can readily be identified and correctly filed. This applies also to any delayed reports from departments of the hospital beyond the ward, such as laboratory, x-ray department, operating-room.

The record clerk, therefore, on receiving the chart will carefully check it to see that its contents actually belong to the patient concerned. Dates of admission and discharge should be checked and the presence of a final note by the ward nurse showing final disposition. Where death occurs, the time of death should be given and the name of the doctor pronouncing death.

It is a distinct aid to have all charts arranged in the same manner, i.e., the sequence of the various component parts should follow a general plan; also, that the sheet chosen as the final one be of an outstanding colour. This latter is especially helpful if and when charts are bound into volumes, as it provides a definite indication of the end of one chart and the beginning of another. These details having been attended to, the chart can be filed in its proper numerical order, and we are ready to tabulate the information contained on the card.

For general purposes this information may be divided into two classes—medical and general. The medical is that which will provide the hospital with a picture of the diseases encountered and at the same time make medical research and review possible. The work is done by the Records Department staff and usually consists of: (a) an index of physicians who send their cases to the hospital; (b) a register of diseases and (c) a register of surgical operations. These three purposes are adequately fulfilled by information giving:

Hospital number, age, sex, admission and discharge dates, diagnosis, operation, end result, pay or free case, name of attending physician.

For the specific demands of the Dominion and Provincial Governments for their annual reports, the following items, in addition to those mentioned above, should be available on the patient's record card for future use:

Name of patient, address and length of residence, birthplace, religion.

Other than these, no further tabulation is essential.

An *index of physicians* using the hospital, and the extent to which they use it, is of value both to the hospital administration and to the doctors themselves. It may consist either of the loose-leaf register or a card index. A separate card or sheet for each doctor should be provided, the record consisting of the hospital number of the patient, the sex, and the type of case (e.g., Obst., Gyn., Med., Ped., etc.)

In all well-run hospitals a *classified index of diseases* is maintained and also a *register of surgical operations*. If the patient's card has been properly completed, the necessary information is available. The register of diseases may be either: a card index; loose-leaf visible index books; or the visible "Kardex." It may be based on one or other of the accepted nomenclatures, but the now widely-used "Standard", which has the official approval of both the American and Canadian Medical Associations, is preferable. The index should provide a space for each disease of common occurrence. Those occurring less frequently may be grouped in accordance with the dictates of the nomenclature. The entries should include the hospital number, the age and sex of the patient, the number of days in hospital, the condition on discharge, or, if the patient died, whether or not an autopsy was done. The name of the doctor should also be included.

The register of surgical operations may also be compiled either from the card or from the reports of the anesthetist made in the operating-theatre. It, also, should be based on an accepted nomenclature, but again the new "Standard" nomenclature is possibly the best. At the least, the register should contain the name of the surgeon presiding at the operation, the hospital number of the patient, and the sex. Such non-surgical procedures as blood transfusions, bronchoscopies, esophagoscopies, removal of plaster casts, Steinmann pins, etc., should find a place in this register. The index may be modified to comply with local usage.

These registers, but particularly the diseases index, are of value in that they:

1. Provide the means of study and research.

2. Refresh a doctor's memory in instances where he recalls treating a certain disease but forgets the patient's name.

3. Are a part of the administration's "account of their stewardship."

A word as to *births* and their registration. No birth registration is effected through the medium of the hospital or the attending doctor. This is a duty for which the parents solely are responsible. The hospital is, however, required by law to submit a list of births each month. Special forms are provided by the Provincial Government and it is advisable that the lists be made in duplicate so that the hospital may file a copy. Every doctor attending a birth is required by law to notify the local registrar of the fact, for which purpose also special forms are provided by the Provincial Government. In the Vancouver General Hospital, for the convenience of the medical profession, the members of the Records Department staff send the doctor's notification. The registrar avails himself of the notices from the hospital and doctor to check delinquent parents.

The *death* of a patient is at all times a serious matter. Therefore, all facts pertinent thereto should be fully recorded for future as well as immediate use. Long after a patient's demise, enquiries may be received from relatives, friends, police, or other official services. In addition, such a register can be the means of keeping the administration properly informed. It should provide for:

Name in full; hospital number; date and hour of death; cause of death (findings of post-mortem, if any); name of attending doctor; name of undertaker; signature of person removing the body from the hospital; name of person giving authority to the undertaker.

All stillbirths should be entered in this register as well an any bodies brought to hospital to be pronounced dead or for the performance of an autopsy.

*The disclosure of information from records*: This is a very important feature of hospital record work, and each type of request for information must be treated on its own merits.

Requests which should be answered without hesitation are:

1. By the doctor who desires information from the chart of a case previously attended by himself or who is now treating a patient who was formerly treated by some other member of the profession.

2. Requests from any member of the executive staff of the hospital.

3. Requests for collection of charts of patients suffering from one disease, provided the information is to be used for research purposes by some properly qualified person.

*Notifiable diseases*: In addition, certain diseases are "notifiable", such as communicable (including venereal) diseases, tuberculosis, and cancer. Such information cannot be withheld, but it is essential that all notifications be handled discreetly to prevent unnecessary dissemination of these data.

Requests not so readily complied with come from various and many sources. It should be borne in mind at all times that hospital records are maintained *by* the hospital *for* the benefit of the patient, *with* the co-operation and consent of the doctor. With this always in mind, there will not be much danger of wrongfully imparting information. No member of the non-medical staff of the hospital should be allowed access to the records without proper authority. No lawyer is necessarily entitled to information. Even if he is acting for the patient he may be doing so against the interests of the doctor or the hospital. Discretion is warranted. A subpena from a judicial court may be advisable.

Requests by patients for access to, or copies of, their own record are infrequent but not unknown. No such demand, however, need be an insurmountable difficulty. It is usually made in ignorance of the fact that in all likelihood, the record (as is the case at the Vancouver General

Hospital) is, under the Hospital By-laws, the property of the hospital.

As in many another situation, "a soft answer turneth away wrath." It should be made clear politely to the patient that any attempt by him to interpret the medical terminology might be fraught with danger to himself. On the other hand, any doctor of his own choice can have access to the record. If this is done, the patient's sense of frustration usually evaporates and he departs in peace.

No casual enquirer should be given medical information unless armed with the written authority of the patient and the doctor. In this category are insurance companies and insurance adjusters, friends, and even relatives. The one big exception to the rule is in the completion of claims for insurance in the event of death. Most insurance policies contain a waiver clause absolving hospitals and doctors. A doctor appointed as Medical Referee in insurance matters should bring with him a letter of authority and the signature of patient and doctor.

There are exceptions to every rule, of course, but once again, it should be observed, discretion is advisable at all times.

*Government returns*: The annual report of hospitals to Dominion and Provincial Governments is very complicated, and every administrator should make herself conversant with its requirements. A careful study of the forms to be completed is recommended. Consolation for the work entailed may perhaps be found in the fact that when one has evolved the answers to the manifold questions of the Government, most of those asked by the hospital itself have simultaneously been dealt with.

Most of the information contained on the admission card of the Vancouver General Hospital is designed to fulfil the purpose of these government returns. In this connection, with the importance attached to figures separating pay and staff cases, the preliminary details compiled for Government returns should be recorded in such a manner that these two classifications can be obtained.

Reference has been made to the necessity of giving information to the Government, other than in the annual reports. It is now incumbent upon all hospitals in B.C. to submit information on the following:

All tuberculosis cases—to the tuberculosis division of the Provincial Board of Health.

All venereal disease cases—to the venereal disease division of the Provincial Board of Health.

All cancer cases—to the Epidemiologist, Victoria, B.C., either directly or through the local medical health officer.

All birth returns—to the district registrar and the registrar at Victoria.

Most of this information is provided through the medium of the individual record, and the work is often undertaken by the Records Department staff. Forms are available for these reports and are supplied by the Government departments concerned.

*Outgoing charts*: The uses to which a patient's chart may be put, individually or collectively, are many. If a hospital is alive to the value of case histories, the calls on the Records Department will be heavy and for this reason it is essential that all outgoing records be registered, the entries showing by whom and where the records are taken and for what purpose. The return of the record should likewise be recorded.

The register is a protection against mislaid and lost records, and also gives an interesting picture of the extent to which the records are consulted. It should be examined regularly for unreturned records.

It not infrequently happens that patients are referred from outlying hospitals to larger centres of treatment, accompanied by their medical record. Upon arrival of the patient, his chart accompanies him to the ward to which he is allocated and remains there until discharge when it

finds its way to the Records Department.

The clerks there discover two things: (1) that it is an "original" chart and (2) that there is no letter requesting its return. The chart is, of course, sent back whence it came but it leaves the feeling that it should have been accompanied by an explanatory note requesting its ultimate return or, better still, that a summary had been sent and the original retained by the referring hospital.

As instances of the positive and negative value of case histories, the following may be cited:

1. A prisoner in whose defence a plea of insanity was advanced. The history and reports on his chart bore out the contention of his counsel.

2. A surgeon wished to give a paper at a surgical convention on a particularly interesting case, but a poor report of the operation performed and an entire absence of the patient's history compelled him to abandon the idea.

*Hospital census of patients*: Among the many functions of a well-organized Records Department is the maintenance of an up-to-date and accurate picture of the movement of the patient population:

Admissions; discharges; deaths; transfers; number of patients in hospital at a given hour daily; hospital days.

These figures, if necessary, could be amplified by showing them in terms of "pay" and "staff" cases, also by ward or building.

The daily admission and discharge lists, aided by a midnight census from all wards, are sufficient as a basis on which to establish the necessary accounting.

One is apt to consider Medical Records in their application to in-patients only. It is just as necessary that extra-mural patients be recorded, such as those sent to the hospital by a local doctor for x-ray examination and report, an electrocardiogram, or physiotherapy treatment. In fact, Dominion and Provincial annual reports ask for this information.

It is not necessary that the Records Department be responsible for keeping such information. The various departments should do so in such a manner that, in years to come, they can make available any extra-mural patient's report and also furnish such information as is necessary for the completion of annual reports.

Some factors in record keeping include: neatness and legibility of writing; concise reports; elimination of verbiage.

*Correspondence*: All correspondence concerning patients should be signed by a responsible and permanent official of the hospital. Copies should be kept for future reference and, for greater convenience, filed with the patient's record.

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# Club Feet Correction

ERMA R. ERSKINE

Under the careful study of our orthopedic surgeon, Gerald L. Burke, B.Sc., M.D., the following have been his treatment and observations on the correction of club feet by the use of Denis-Browne splints:

We are all too familiar with plaster casts which were wedged and wedged, re-applied and wedged. Too often the end results were stiff, partially deformed, undersized feet with thin, under-developed legs, particularly noticeable in unilateral cases, in contrast with the chubby normal feet.

The logical theory of the cause is the oldest. It was propounded by Hippocrates who stated that the deformity of the feet was due to their moulding by

*The old way, with Plaster of Paris*

the wall of the uterus. This conception has been stoutly championed by Mr. Denis Browne, F.R.C.S., of London, England, and his treatment based upon it has been incomparably the most successful. The evidence is in its favour. The shape of tissues can be radically altered after birth by external pressure; for example, consider the tiny feet that Chinese ladies used to affect due to the tight bandaging of their feet in childhood. Similarly, pressure is capable of altering the shape of parts of the body before birth.

We have all observed the calcaneo-valgus position of the normal, newborn child's feet, the backs of the feet having been forced upwards and outwards toward the outer side of the leg by the pressure of the wall of the uterus. It needs only light pressure on the sole of a newborn child's foot to cause the little toe to touch the outer side of the leg near the fibula. This position is automatically self-correcting as the child grows older because the weak muscles which might maintain it are opposed by the most powerful muscle groups below the knee.

If a child does not take the pressure on the soles of its feet, the only other part of the foot on which the pressure can be taken is on the outer side and some degree of club foot will result. The movement of the child *in utero* make no difference to the relative position of the feet. There is not enough room as a rule for a child to move the foot from the club foot position to calcaneo-valgus. I have seen a photograph of a specimen in the University College Hospital in which the anterior half of the uterus is replaced by a glass which clearly demonstrates this point.

In the treatment it is necessary to concentrate on the most important element of the deformity which is the curving inwards of the longitudinal axis of the foot, and the most important part of this curving is in that portion of the foot lying in front of the ankle. If this part of the deformity is corrected, all else shall be added unto the foot, that is, the secondary elements of equinus and varus are automatically corrected if they are present. There is not only structure to consider in a disability of this sort, but there is also function. The most important interference with

*Club feet-bilateral. Before treatment.*

*Club feet-bilateral. Before treatment.*

*Club feet-bilateral.*
*Denis-Browne splints.*

*Wearing boot splints.*

function comes from lack of muscle balance—the powerful muscles are favoured and the weak muscles stretched. To correct a disturbance of this sort it is not enough to correct the deformity. The muscles must be made to work against each other in the corrected position. Holding of the limb motionless in plaster has no effect in equalizing muscle tone once it has been upset.

Denis-Browne splints fulfil these requirements by allowing and stimulating the child to kick vigorously in the splint. Thus, it works its own feet into shape. We apply the splints at the earliest possible moment.

The feet are painted with tincture of benzoin compound, cleaned with French cleaner—we do not wash them—then strapped separately to the metal footpiece which has, securely glued on, sponge rubber soles. Five strips of adhesive are used for each foot, then the foot pieces are attached to a metal cross-bar in a neutral position. During the first two to four weeks the feet are gradually externally rotated until the foot is in alignment with the bar. As soon as the inversion and rotation of the foot are corrected by this means, the cross bar is bent to an angle of 35°, about 2 inches from the end. This corrects the equinus deformity of the foot. Our general rule is change of adhesive three times weekly for the first two weeks, then twice weekly for two to three months, or until the foot is fully corrected.

Caution must be taken in removing adhesive. Many an untrained hand at applying and removing Denis-Browne splints has delayed correction due to too hasty removing of adhesive tape from a tiny foot. Great care must be exercised at this point as skin irritation can be caused as well as skin breaking; if this occurs treatment is delayed as well as pain caused the patient.

Under the expert training of Miss Dorothy Longley, R.N., who is in charge of the Medical Social Service Department of the Crippled Children's Hospital, Vancouver, our nurses are taught to apply and remove the Denis-Browne splints.

After the adhesive has been used and complete correction obtained, boot splints are applied to be worn night and day for three months. (These are removed for bathing only.) Finally, boot splints are worn only when the child is sleeping. This stage of treatment continues for at least twelve months, and during this period the mother is instructed to manipulate the feet at least three times daily.

As soon as the child begins to walk,

*Note improvement of feet when splints are removed.*

heelless boots with outside tilts are ordered. These are worn until the child is three to four years of age. . ,

From October, 1944, to October, 1945, fifty patients were treated. Results —good!

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# The Shortage of Nurses

LORD HORDER

*Editor's Note*: By special permission from the *Sunday Times*, London, England, we are privileged to republish this sympathetic yet provocative commentary on the present acute problem of nurse shortage. Lord Horder's interest in nursing and his efforts on the behalf of the nurses in Britain are too well known to require comment. Many of the difficulties being encountered in Britain have their counterpart in Canada. True, hospitals here did not have to lower their admission requirements generally during the war years but, in many instances, tasks have devolved upon the student nurses which were in no wise learning experiences. To have their cause championed by this astute friend of nursing augurs well for some attention being gien to the perplexing problems associated with the supply of nurses.

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What can we do, and do now, about this "shortage of nurses"? For the past four years it has been my privilege to act as an objective and (I trust) impartial Chairman of the Nursing Reconstruction Committee, by which the problem of "The Shortage of Nurses", so ably discussed in your columns by Miss E. E. P. MacManus and Dr. Charles Hill, has been studied not only by many types of nurses but by those whose work brings them into close contact with nursing in all its branches. I hope I may not be thought presumptuous, therefore, if I follow the writers of those articles with an outline of some of the basic factors which, in my view, lie at the bottom of our present perplexities.

That the nation is deeply concerned at this crisis in the functioning of a vital part of its health services is evident from the widespread controversy the crisis has promoted — controversy which centres round two main issues. On the one hand the governing bodies of hospitals are pressing for anyone who can be induced to don cap and apron to be swept into the recruiting pool in order to make good the present grave shortage of personnel. On the other hand, an uneasy general public, vaguely aware that the nurse, for all her national salary scales, is not getting a square deal, demands a patch-work of superficial remedies instead of examining the underlying complaints and arriving at a correct diagnosis.

The nursing profession has suffered from some faulty handling in the past. Just as we are making an effort to reverse certain disastrous tendencies we are caught by this clamour for "pairs of hands" at any price, and we are in danger of sacrificing the whole future of the nursing service in order to meet the short-sighted, short-term policy that is put before us.

It is assumed that, in order to make good the shortage of nurses, we must strain every nerve to recruit over twenty thousand students for admission to hospitals which train for the various parts of the nurses' State Register. This huge estimate is based on two considerations. First, the wastage among recruits, always high, has risen to well over 50 per cent, since the day when, owing to the war, all entrance requirements for training were

waived. Secondly, the figures are influenced by the ever-increasing number of vacancies which training schools have to offer. The number of nurse-training schools runs into many hundreds. Indeed, it is the ambition of all hospital authorities to conduct the approved school, because such an arrangement stabilizes and improves the staffing position. Any suggestion that the number of training schools should be reduced to those which, independently or in combination, can really give a comprehensive training, and any suggestions that some entrance standard for recruits should be re-introduced, meets with vehement protests from hospital boards.

It is fundamentally wrong that the education and training of the State registered nurse on which, in the final count, so much depends, should be subordinated to a second and quite unrelated problem, the demands of the hospital for staff. What is the alternative? Let us examine the tasks the student nurse has to perform. At present, student nurses make up far and away the largest section of the hospital's personnel. Quite apart from the burden of domestic work which has fallen to the lot of the student nurse in wartime, she has always carried the main weight of the routine nursing care. Our first task, therefore, must be to analyze the work to be done, and then consider by what types of staff it could most fittingly (not most expediently or even most cheaply) be performed; to the student nurse should fall only such duties as her training in technique, responsibility, and self-discipline require.

Having, by a process of "job analysis" to which hospital administrators should at once apply themselves, overhauled the hospital's staffing needs, we should avail ourselves of modern selection methods such as have been used with such success in the Services, and designed to assess not only the candidate's cultural or scholastic background, but his or her ability to profit by a specialized course of training. In spite of opposition, hospital schools training for the State Register should be limited to those which can offer a wide and sound training, though this need not preclude many small and uneconomic schools from playing a part in co-ordinated schemes. Other schools, together with institutions for the chronic sick, where the need for a stable nursing staff is no less urgent, should have every help in the essential task of training assistant nurses. Along with these schemes revolutionary changes are called for in the training and *promotion* of orderlies and domestic staff.

This conception of our obligation to the student nurse will admittedly cost money, but both the Athlone Committee and my own (which was called into being in order to reaffirm and to expand the recommendations of the Athlone Committee) have emphasized that the training of the nation's nurses is a national concern to which the nation must contribute in cash, and for which, I firmly believe, the public is willing to pay.

### Radical Changes

If modern methods can check wastage and frustration in the Services they can do so in the nursing profession but the changes must be radical and wholehearted. Certain words and phrases so glibly applied to nursing must be made to mean what they say. For example, the student nurse must be a student of nursing. Again, we talk of a girl as an entrant to the nursing *profession;* let us see to it that she is given a proper chance to acquire the professional touch. And, yet again, we speak of the nurse's training; this training must *be* a training, not just a work assignment. The status of the trainee must be that of a student; her training must be comprehensive, and must be so arranged that she is withdrawn from the

wards for periods of several weeks at a time to concentrate on study classes, lectures, and clinical demonstrations; moreover, she should be able during the latter part of her basic course to progress towards qualification in some chosen speciality.

And so I enter my plea for the long-term view, a view for which my Committee stands. In the interest of the community we refuse to be jockeyed out of our position by an opportunist clamour born of a confusion of thought. Let us be clear and let us be honest. What is going to be our answer to the intelligent girl who asks what it is that we offer her if she enters the nursing profession? Do we say "a carefully planned curriculum which will give you a career of intense interest and a chance of unique service to society" —or, "we want you badly because the hospitals are desperately short of domestic staff"?

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# Scarborough Hall – Neuropsychiatric Centre

Anna C. McArthur, B.A.

Scarborough Hall, formerly the Guild of All Arts, was opened by the Department of Veterans Affairs as a neurosis centre for service men in May, 1944. The hospital consists of one main building of fifty beds, two separate units of twenty-five beds each, where insulin therapy is administered, and a studio workshop.

Each patient, on admission, writes his own history under the supervision of a nurse. It is most important that the nurse makes a good contact with the veteran since this will be his home for a while. After the patient has been examined by the resident medical officer, he is assigned to one of the insulin wards where he receives his insulin therapy.

In the modified insulin treatment the dosage begins with ten units, gradually increases to an optimum dose producing sound sleep but not coma. This treatment relieves tension and restores body weight. The nursing care of these patients is very important. Constant vigilance for the danger signs is demanded with fifteen-minute observations recorded on the chart. The nurse must watch for a pulse below 40 or over 120, for abnormally shallow respirations, cyanosis, vomiting, severe excitement, epileptic fits, general signs of collapse, and signs of excessive depth of coma, i.e., extensor spasms. Two nurses are in attendance on each of these wards while treatments are being given. On completion of the patient's series of treatments, he is transferred to the main building where he remains until his discharge. The usual period of hospitalization is six weeks.

The nurses, who are quartered in the main building, spend a great deal of their time with the patients. They must mingle with the men, enter into their sports and festivities, help them with their problems and in all assume the role of a "big sister". They must also help the psychologist with the psychometric tests.

A conference is held every Friday afternoon at which the case of one of the patients is presented. The nurse reads the history which she has obtained from the patient. This is followed by the psychologist's report on the Wechsler-Bellevue, the Raven-Matrix and Minnesota tests, the social worker's and the occupational therapist's reports, and finally the doctor's history. A gen-

eral summary and discussion follows and this ensures complete team-work in the therapeutic approach.

The patient's day is well planned so that each man is engaged in some project in which he is interested. Patients receiving insulin therapy begin their treatment at 7:00 a.m., are terminated at 10:00 a.m. After dinner at the main building they are ready to enter into the various activities along with the other patients. In the studio workshop, carpentry, weaving, pottery, and painting are supervised by graduate occupational therapists. In the summer months the men spend a great deal of time out-of-doors and work in individual gardens. Calisthenics and phonetic classes for stammerers are given. The patients care for their rooms and are posted to kitchen fatigue and various other duties.

There is a compulsory lecture once a week on some educational subject, such as musical appreciation, electricity, public speaking, or citizenship. There are compulsory lectures daily on the physiological reactions of the body, when the patients learn that their symptoms are normal reactions of the nervous system. These latter lectures are approached in commonsense terms, bringing the men into the discussion whenever possible so that they talk about their own cases. The evenings are filled with planned programs, such as dances, bridge parties, and movies.

In these ways the days are almost completely filled with activities which are most beneficial to our neuropsychiatric patient. Add to these benefits the beautiful and delightful surroundings at Scarborough Hall, plus the well-planned meals and homelike atmosphere and we might rightly conclude that this centre is indeed the ideal setting for successful modern neuropsychiatric treatment. We are able to accomplish the resocialization of the individual into full community life. Ninety-eight per cent of our patients return to immediate employment.

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# Facing the Facts

HELEN A. SAUNDERS

With demobilization and the return to civilian nursing, those of us who have served with the armed forces find ourselves in a unique position which enables us to survey the entire field of nursing, unprejudiced by loyalty to any *one* branch. We have difficult decisions ahead and, alas, the picture we see is not a pretty one. The unhappy memories many of us have of former civilian experiences are not very encouraging. Sometimes we feel we would do anything rather than go back to nursing as we remember it. The probability that the majority of returning army nurses will choose the public health field stands as evidence of the fact that in that field alone is there hope of professional satisfaction. This unrest cannot be passed off merely as an expected feature of the trying period of adjustment to civilian life. It is just as common among our civilian nursing sisters. There seem to be five major causes for dissatisfaction. Not wishing this to be simply a list of complaints, I have tried to add to each suggestions intended as constructive solutions of the problems involved.

## UNFAIR SALARIES

Even with the present increased salaries, which for the general duty nurse

are seldom more than $100 a month with maintenance (a great many hospitals do not even offer this amount), she is still receiving the same or less remuneration for her skilled work than the union-protected waitress, taxi-driver, cleaner, or other unskilled labour groups. Yet she works hand in hand with well-paid doctors. She prepares their patients for operation and assists during operations, sometimes in the place of an assistant doctor. She watches their maternity patients through long hours of labour, gives them anesthetics, sedatives, and intravenouses, and occasionally also delivers the baby. She has the responsibility for recognizing symptoms and signs so important in looking after the very ill and post-operative patients, and of knowing how to administer emergency treatments in the absence of the doctor.

All this responsibility we accept with pleasure. That is what we trained and specialized for — *but* the salary that is paid for such skilled assistance is often lower than that paid the cleaners in the same hospital! How can the intelligent woman settle down happily to such an unjust state of affairs? Not only are all salaries still too low but there is no fair standardization of salaries within certain hospitals, where benefits in salary depend, not on experience, seniority, or qualifications, but often on an individual's aggressiveness in demanding them.

I suggest: 1. That we urge, through the Canadian Nurses Association, that there be a definite *minimum* monthly salary for general duty nurses. This salary should be not less than $120 *plus maintenance*. At the present scale of wages and salaries paid to those in other walks of life I would judge this amount the minimum commensurate with a registered nurse's skill and training, and her value to the community.

2. That we urge also, through our National Association, that hospitals offer definite financial benefits, over and above this amount, to those general duty nurses who have post-graduate courses or years of experience, or are carrying considerable responsibility though still classed as "general duty nurses", and also for those on night duty.

3. Finally, I would suggest that *now* is our golden opportunity to do this urging. When Government-sponsored Health Insurance plans become a reality, hospitals should no longer put us "on the spot" by saying helplessly, "We need you in order to keep going at all, *but* we can't afford to pay you what you are worth to us".

### Unsatisfactory Hours of Work

The straight eight-hour day is still a dream in most hospitals. The broken eight-hour day, i.e., 7 a.m. to 7 p.m., with three hours off some time during the day (if not too busy), is still the usual thing in hospitals which say they have an eight-hour day. This shift simply does *not* permit the nurse time or energy to join in the normal social life of her community and to have recreation which is as much her right, and is as essential to her mental health, as it is to other individuals.

Obviously, the only thing to do is again to call on those members of our association who represent us, to insist that the straight eight-hour day be instituted, still maintaining, of course, the hard-won day off a week and a necessary rest cure of four weeks' holiday *with pay* per year.

### Lack of Public Sympathy

The ignorance of the general public regarding nurses' duties, responsibilities, salaries, and conditions of work is probably the greatest hindrance towards better conditions. Outside our own long-suffering relatives and intimate friends, most people still cling to one

or other of the following ideas concerning nurses:

1. *The Romantic Theory*, in which nurses are supposed to receive hundreds of dollars a month, be fed on chicken and angel-food cake, and spend their time taking temperatures, arranging flowers and stroking brows.

2. *The Sairy Gamp Theory*, in which nurses are classed as "high-class" help, very necessary in time of sickness, but not exactly desirable people to cultivate socially.

3. *The Idealistic Theory*, in which nurses seem vaguely confused with religious nursing Orders, to the extent that it is not at all understood that they are entitled to just as reasonable hours of work and as adequate financial recompense for their services, as any other secular professional group.

I suggest: That we expand our publicity program in each province by radio talks, newspaper and magazine articles, and short films at club meetings, to advertise ourselves a little. We should continue our efforts until old-fashioned beliefs are banished and we are recognized and respected generally as well-educated human beings, giving an essential public service, and with the same claim to good salary and hours of work as our sisters in other professions.

### Exploitation of Services

Student and graduate nurses still are obliged to include in their daily work such non-nursing duties as: cleaning furniture, sinks, cupboards, refrigerators, apparatus and equipment of all sorts; making endless dressings and supplies (most of which are now obtainable ready-made); folding and sorting large quantities of linen; washing, testing and mending large piles of rubber gloves; washing out, by hand, dirty diapers, soiled clothes and sheets, and in some hospitals even the dirty dressings, before the hospital laundry staff will even deign to handle them. To do all this the nurse must hurry through her nursing duties or she would never be finished. The results are dissatisfied patients and worn-out, resentful nurses. Yet hospital boards, refusing to acknowledge the injustice of the situation, still leave all this extra work to their nursing staffs by simply not employing sufficient sub-staff. Their excuse, in itself a frank confession of exploitation, is that they are forced to so use nurses to enable their hospitals to meet expenses.

I suggest that hospitals were built to serve the public. They should, therefore, be publicly supported to a far greater extent than they are. It is the governing bodies of these hospitals that should force this issue by refusing to exploit their staffs, and so supply second-rate care for their patients. Unless, however, we nurses put a tactful foot down on non-nursing duties, (except, of course, in emergencies), we may expect the present line of least resistance to continue to be followed by hospital boards.

### Lack of Professional Unity

To face facts, we must admit that there is far too much petty warfare and intolerance amongst nurses themselves. The childish back-biting we have all heard going on in a big hospital is no rare occasion, but, alas, seems to be part of the atmosphere of many hospitals. Graduates from different hospitals on the same staff too often condemn each other's school of nursing from little things that are done differently. There is too commonly a lack of sympathy and understanding of each other's aims and problems. So great is the lack of unity and common interest that chapter leaders have a hard time getting members to come to meetings, without which we would soon cease to be an organization at all.

I suggest: 1. With our system of chapter and district meetings available

to every nurse, responsible to a provincial organization, and in turn to the National Association, we have at hand the structure of the most powerful association we could have to help us — if we would only *all* support it, instead of turning individually to various outside groups for help.

2. There should be regular staff conferences in hospitals, patterned on the same democratic lines as those in public health organizations. At these conferences representatives of the student body, the general duty staff, supervisory staff, special nurses, medical staff, dietetic, laboratory and sub-staffs, would be obliged to attend during working hours. It could not help but result in better co-operation between services within individual hospitals.

3. A personnel relations counsellor should be on the staff of every large hospital and school of nursing. That person should be a nurse of wide experience and additional training in vocational guidance and psychology, with the same course in "public relations" given to those in similar positions in business and industry.

### Further Suggestions

Less drastic suggestions to add attractiveness to the general duty field might be:

1. Ability to transfer, on exchange system, from one hospital to another in different parts of Canada, or in a different country.

2. A better break for night nurses, to include the following: (a) A comfortably fitted room, with a radio, books, etc., for the night nurses in their hours off duty instead of the usual bumpy couch in a waiting-room, some place where she may listen to the radio without fear of disturbing patients. (b) Meals at night should be freshly cooked and nicely served just as in the day — not twelve-hour old, warmed-over food, such as is the general rule at present — to save night kitchen help! (c) Transportation on and off duty in the middle of the night should be arranged by the hospital, especially in certain big cities where the district round the hospital is not always one in which it is wise to walk unescorted in the wee small hours.

To close, I would like to assert that we are not blind to the efforts of those who have already done so much to improve conditions for nurses, especially against great odds. We are only impatient to see considerably *more* improvement — and *soon*.

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## Dr. Heagerty

Dr. J. J. Heagerty, former director of public health services for Canada, died recently in Ottawa. Dr. Heagerty was instrumental in assisting the Canadian Nurses Association to secure Federal aid for nursing during the war years.

Dr. Heagerty was associated with public health work for more than thirty years. He was the author of the two-volume book, "Four Centuries of Medical History in Canada" and its shorter companion volume, "The Romance of Medicine in Canada." As chairman of the advisory committee on health insurance, Dr. Heagerty prepared the extensive report which formed the basis for a draft bill on health insurance.

Formal recognition of his work was made in 1943 when he became a Companion of the Imperial Service Order.

# HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

## A Noiseless Tonsillectomy Morning

JESSIE COCHRANE

Tonsillectomy morning in a children's clinic, without screaming and terror? Does it ever happen? It can happen. It requires time, patience, and an understanding of the emotional needs of young children. The child is impressionable and susceptible to fear because his understanding is limited. He requires time to adjust to new experiences for the same reason. How can we help the child to meet the experiences of separation from his parents and undergoing operation, with a minimum of psychic trauma?

The first steps are taken when he attends the ear, nose and throat clinic, prior to operation. He is met with a friendly greeting. He is given a feeling of security, by a smile, by a leisurely atmosphere, by offering him a scrap book or a toy. Older children go to the examining room first while a young or nervous child is permitted to watch. He may see and touch the instruments if he wishes to do so, when his turn comes. Questions of parents and child are answered truthfully and the mother is encouraged to tell the child that he will return for a three-day stay while his tonsils are removed.

The day has arrived! Eight mothers have been asked to bring eight children to the hospital at ten o'clock in the morning. As soon as the Admitting Office routine has been completed, the children and parents arrive at the ward, which has only eight beds in it.

The children may wander about at will, gradually becoming acquainted with the surroundings while waiting for dinner. Self-selection of beds and toys at this time is encouraged. It is much more satisfactory to hop into a bed of one's own choosing, isn't it? If each child is permitted to tie his bed tag in place, that bed becomes a symbol of security.

Dinner is a party! An empty room is turned into a dining-room. A table covered with a cloth is prepared, flowers adorn the centre when they are available. Occasionally there is a paper hat for each child and parents are invited to stay and watch the party. But it is the attitude and friendliness of the nurse that colours the occasion and makes it happy. A calm, pleasant atmosphere creates confidence in parents and children. The children need a good full course meal the day before operation. This is a way to ensure that they get it.

After dinner the nurse obtains, informally, an accurate medical history from each parent. Each child is undressed and placed in bed by his mother or father. There is a careful explanation to each in the presence of the child that there will be no visiting privileges. Each child is assured that mother or father *will* return to take him home and actual parting is accomplished as quickly as possible.

Good-byes are often tearful but the nurse provides toys and plays children's records on the victrola. She has a period of one to two hours to use all her knowledge of and skill in group play before her admission routines begin.

Crying is ignored for a period of from twenty to thirty minutes. It is surprising how quickly a crying child, who is ignored, will recover and enter into group activity. There is a way to deal with persistent crying. A child who has an uncontrollable impulse to continue crying may do so, but he must cry alone. The dining-room now becomes a "crying room." The nurse tells the child about it. It is not a punishment. The room is not dark. The child may take a toy. The nurse is not angry. She understands the desire to cry, but crying annoys the other children. Little Mary decides whether she wants to stop crying or go to the crying room and cry it out by herself. Often she does go and cry by herself, usually for a short period only. Occasionally a child will ask to go to the crying room at another time during the period in hospital.

While baths are being given the nurse explains about the thermometer, the bed pan, and the urinal. All procedures are done first on the oldest or the best controlled child in the group. Then comes a light supper in bed. At sleep time corn syrup, to prevent acidosis, is given as ordered. To ensure a good night's sleep, nembutal is given in the corn syrup, dosage being according to the age of the child.

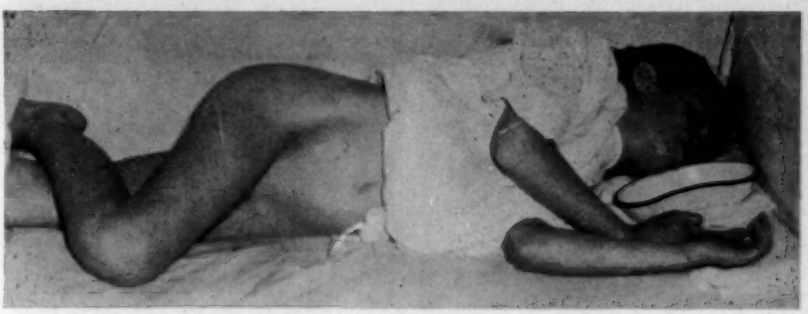
*Nurse holds the child's chin.*

At seven o'clock the following morning each child is wrapped in his bath blanket and taken out to the waiting-room. This can be made an occasion for fun. We sometimes pretend that it is a picnic in the country and when the pre-operative hypodermic of morphine and scopolamine is given at 7:30, the bees are stinging us. Rarely is there any fuss made. After the hypodermic game, the nurse reads a story or simply talks to the children about familiar things until each child has fallen asleep.

Operations begin at 8:00 a.m. Psychotheraphy is continued when the child is to be taken to the anesthetic room and meets the anesthetist. Some children do cry during induction but many go "under" without weeping. Usually all are quiet and rarely struggle.

Vinethene is used for induction, then open drop ether, nitrous oxide and oxygen, sodium pentothal or curare for the second stage. An intratracheal tube in introduced and the patient held with ether during the operation. The suction is used continuously throughout the operation and is applied to the intratracheal tube as it is withdrawn at the end. The patient is turned immediately to a lateral position with head lowered and is carried in this position to his bed.

Post-operatively, the foot of the bed is elevated two notches. This facilitates drainage and hemorrhage can be observed immediately. The patient remains on his side with his back to the nurse. The lower leg is straight and the upper leg is flexed to act as a prop. (See the accompanying photograph of a little patient.) The arms are arranged to give good and easy chest expansion. The nurse places one hand on the child's forehead. her other forearm holds the child's shoulder in place, while the thumb is placed on the angle of the jaw pushing it forward. This keeps the base of the



*Child's position on return to the ward.*

tongue away from the back of the throat, ensures an airway, and prevents the clamping of the jaws if there is spasm. The chin is kept pointing into the kidney basin. The index finger is used to keep the lower lip open. Care must be taken not to use pressure with the index finger. If the chin is pressed down the airway is cut off. Cyanosis is usually caused by lack of oxygen. By giving the patient a good airway, he can be carried safely through vomiting and spasm.

This position is held until the patient reacts. Then the bed is lowered and the patient permitted to assume any position which he desires, outside of covers, head at bottom of bed, etc. Any attempt to keep him in a fixed position will arouse resistance. With the above technique there is no need of a bed-side table set up; no need for suction, tongue-forceps, or mouth gag.

When all patients have reacted, the ward is darkened and quieted. The nurse goes immediately to a child each time he rouses to assure him. She gives a hot water bottle for earache, a cold face cloth for headache, or an ice collar for sore throat, mainly for psychological reasons.

Ice is given to suck at 12 noon; clear fluids as tolerated after 3:00 p.m.; milk is given in the evening, and soft diet the day following operation.

The second day quiet, individual play is encouraged and the children are discharged on the third day. There is often an emotional outburst when the parents first appear to take the children home, but on the return visit to the clinic for a post-operative check-up, they are invariably friendly and unafraid.

The time spent and individual attention given have proven well worthwhile.

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## Look at the Address on the Wrapper!

Every little while we receive letters from subscribers bemoaning the fact that they have missed one, two, or three copies of the *Journal*. It always strikes us as being very peculiar that the subscriber waits sometimes as long as six months to write in with such a complaint. If you have been receiving your copies regularly and they suddenly stop coming, there are two possible reasons. It may be that your subscription has lapsed and that you have overlooked the renewal notices (please note that that word is in the plural) which we have

mailed to the address we have on our mailing list. There is only one thing to do about that, of course — send in your renewal and the *Journal* will begin arriving again.

The other and much more common reason why the issues do not reach you is because you no longer live at the address which we have on our list. Sometimes the postmaster sends us a notification when you have listed your change of address with him. Sometimes family or friends, your former landlady, or your school of nursing forwards the magazine to you. This business of forwarding mail can become quite burdensome especially when numerous members of a graduating class leave their school of nursing and fail to inform us of their whereabouts. Student nurses please note!

Look at the wrapper that you have taken off this copy. Is your name spelled correctly? Is your street address right? If there is *any* error, please write us immediately about it. It only takes us a jiffy to make the notation of change on your card in our files. It only costs us a few cents to have your address altered on the addressograph plate. And you will continue to receive your magazine regularly no matter where you may roam — if. *Please tell us if you move.*

## Canada Year Book, 1945

Keeping up-to-date with what is going on in Canada is one of the "musts" for every nurse if she is to be able to discuss developments intelligently. Too often, we tend to become bogged down with our own professional matters, and are unaware of the magnificent contributions our country is making in divers directions. To offset this inadequacy of information, the publication of the new edition of Canada Year Book, which has just been announced by the Dominion Bureau of Statistics, presents a useful source. Far from being a dry collection of tables, it contains feature articles of special importance which give added meaning and substance to the statistical and analytical material that constitutes the basic chapters. Special articles included in this issue include such topics as, Canada's Growth in External Status, Canada's Part in the Relief and Rehabilitation of the Occupied Territories, etc. The reader is kept abreast of present-day developments by textual analyses and discussions in the chapters on Social Welfare and Reconstruction, which include such matters as family allowances, health insurance, and post-war planning for full employment.

The regular price of the Canada Year Book (cloth-bound edition) is two dollars a copy. By a special concession, a limited number of paper-bound copies have been set aside for bona fide students at the nominal price of one dollar each. Application, with remittance, for special copies must be forwarded to the Dominion Statistician, Dominion Bureau of Statistics, Ottawa. Regular copies may be procured from the King's Printer, Ottawa. Remittance should be made by money order, postal note, or accepted cheque made payable to the Receiver General of Canada.

## Preview

Why was there such a tremedous expansion of industrial nursing during the war years? Is there an equally important role for the nurse in the preservation of the physical well-being of the workmen in the new industrial expansion of post-war Canada? **Frances C. Harris**, from her vantage point as consultant on industrial nursing, Division of Industrial Hygiene, Department of National Health and Welfare, believes that there is a very real contribution that Canadian nurses can make in building up the industrial nursing services. Every public health nurse should read her article in the April issue.

# PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

## Teachers' Health

CLARE FRANCKUM

An amendment to the Education Act for the Province of Quebec was passed in 1941 requiring all teachers to have an annual medical examination and a satisfactory chest x-ray report. In the case of re-engagement the x-ray was not required to be repeated unless requested by the school commissioners. Each municipality has made its own arrangements for carrying out these requirements, using local medical facilities.

The Protestant Board of School Commissioners of the City of Montreal made arrangements to comply with these provincial regulations for the session 1941-1942. The law was interpreted to include all employees who come in contact with the children in school, that is, principals, supervisors, teachers, office assistants, caretakers and cleaners, etc., making a total of approximately twelve hundred employees. All these were x-rayed in groups at the Royal Edward Institute, now the Royal Edward Laurentian Hospital. The School Board financed this work. The Montreal Health Department had been examining the staff of the Catholic School Commission for some time and now offered to extend their work to include the staff of the Protestant Board. Members were given the option of being examined by their own physicians at their own expense or being examined by the doctors of the Health Department free. The Health Department supplied the forms to be used in either case. Duplicate copies were made of all x-ray and medical reports, the Health Department retaining one set while the others were submitted to the Protestant Board.

Early in 1942, the Montreal Protestant Board asked the late Dr. Grant Fleming, director of the Department of Public Health and Preventive Medicine at McGill University, for suggestions for a health service. He submitted an outline for such a service and at his suggestion a health adviser was engaged part-time, and a public health nurse full-time. Suitable accommodation and equipment were provided and the Health Service was launched towards the end of June, 1942.

The chief work of the Health Service has been the examination of new employees. Prior to the passing of the 1941 amendment, all new employees were examined at their own expense. Due to war conditions there was an unusually large turnover of staff. All appointments for x-ray or medical examinations have to be made outside of school time yet convenient to hospital hours and doctor's time. Sickness records have been kept and home visits made by the nurse when necessary. The annual examinations are still arranged by the Montreal Health Department but the reports are reviewed by the Health

Service. The board's medical adviser makes recommendations for special examinations or repeat x-rays when necessary.

Primarily the law was passed to protect children from possible tubercular infection among the adult school staff. To date our records do not show any great danger from this source. The pre-employment and periodic examinations have brought under control a number of remedial conditions. The Health Service is too young and the turnover in staff has been too great to make any comparable statistics as yet. We hope to extend our services more fully to keep the staff healthy and to reduce absenteeism.

## Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

*Catherine (Lemon) Debeau* has been appointed to the National Office to do the professional reviewing of the discharged Metropolitan Life Insurance Company case histories. Mrs. Debeau has been with the Victorian Order for many years, first in Hamilton, later as nurse-in-charge of the Brockville Branch, and more recently she has been employed for half-time with the Ottawa Branch.

*Doreen Denby* (Vancouver General Hospital and public health course, University of British Columbia) and *Elizabeth George* (Women's College Hospital, Toronto, and public health course, University of Toronto) have been appointed to the Toronto staff.

*Helen Waring*, who recently completed four years' service with the R.C.A.F. Nursing Service, and was previously nurse-in-charge of the North Bay Branch, has been appointed to the Montreal staff.

*Mrs. Elizabeth Lovegrove* (Royal Alexandra Hospital, Edmonton, and public health course, University of Western Ontario) has been appointed to the Vancouver staff.

*Elizabeth Riddell*, who resigned from the Order two years ago to join the R.C.A.-M.C. Nursing Service, has been appointed as senior nurse on the Victoria staff.

Having completed the four-month course in public health nursing supervision at McGill University, *Marion Shore* has returned to her former position as supervisor on the Halifax staff, and *Ruth Franklin* has returned to the Vancouver staff.

*Margaret Wanless*, having completed a two-month period of introduction to Victorian Order nursing on the Toronto staff, has been appointed to the Dundas staff.

*Mrs. A. J. Moffatt* has resigned from her position as supervising nurse on the Montreal staff to join her husband. *Mrs. Marion (Whebby) DeBeck* has resigned from the Halifax staff to be with her husband in Victoria, B. C. *Helen Stuart*, formerly on the Ottawa staff, and *Anna Stewart*, formerly on the Border Cities staff, have retired from active nursing. *Marion E. Robinson* has resigned from the York Township staff. *Mrs. Cecile Lassaline* has resigned from the Border Cities staff.

## V.O.N. Scholarships

**The Victorian Order of Nurses for Canada announces that scholarships, to the value of five hundred dollars each, the same sum as was given in 1945, are being offered to graduate nurses for the purpose of taking post-graduate courses in public health nursing at a Canadian university of their choice, commencing in September, 1946. Previous Victorian Order or other public health experience is desirable but not necessary.**

**Interested applicants should apply as soon as possible to: Miss Elizabeth Smellie, Chief Superintendent, The Victorian Order of Nurses for Canada, 114 Wellington St., Ottawa, Ont.**

# GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

## Arthritis

JOSEPHINE MONTEMEURO

Before I came to nurse at Mineral Springs Hospital, I hardly realized that the dreaded disease, arthritis, existed. I was amazed to find that not only the aged but young people and even children are stricken and often horribly crippled before they find their way to Banff for treatment. It is pathetic to see some of them come in, mentally ill as well as physically, with a look of pleading on their faces which seems to say "please help me". And that is what is attempted a Mineral Springs Hospital under Dr. Dean Robinson's careful guidance and with the help of the Sisters of St. Martha.

The nursing of arthritic patients is vastly different from nursing a post-operative appendix or something of that nature. The patient remains hospitalized over a long period of time and the nurse must be bright, cheerful, and friendly if she is going to make the patient happy and contented during his lengthy stay. A friendly smile is certainly a good tonic for anyone. Hope revives when the sufferers find a doctor and nursing staff eager to help them on the slow road back to health. They realize there is no short cut.

The treatment of arthritis is protracted. First and foremost, rest in hospital for many months is found necessary. The disease is like a prairie fire — one may think it is out when it is just smouldering. If the disease is caught in the early stages the rest in hospital is shortened. When a tuberculosis patient is told he has a spot on his lung he immediately thinks of going to a sanatorium. Rheumatic patients must be taught the same. The nurse is the policeman on the beat when it comes to enforcing the rest periods. After dinner each day the nurse makes the patients comfortable, pulls down the blinds, opens the window, shuts the door and the patients must try to sleep or at least relax until two o'clock, when daily temperatures are taken. We cannot stress enough the importance of rest and relaxation in the treatment of arthritis.

The building up of the patient's morale and keeping him reasonably buoyant during his long stay in hospital cannot be too highly regarded. I was impressed with the way this was done. There is a bingo party or some form of entertainment regularly and everyone contributes to make it a huge success — something special for every occasion. You would be surprised how the patients look forward from one party to the next. They leave their worries at home and enter into the hospital life whole-heartedly.

Of course the diet cannot be left unattended and here again the nurse makes sure the patient is getting the

proper nutritional care. If there are signs of vitamin deficiency the doctor orders the necessary supplement. Iron is required in some cases. Sweets are restricted, while condiments and fried foods are eliminated. If a patient is underfed, we strive to build him up; if he is overfed, we try to reduce his weight by carrying out the doctor's order, putting him on low-caloric diet.

The ambulatory patients enjoy their plunge in the sulphur pool and it is quite a sight to see them on their way down immediately after breakfast each morning. They get to know one another here and the hospital doesn't seem so strange to them. If the patients are unable to walk they are taken to the sulphur baths in wheel chairs. The baths, apart from any medicinal value, are soothing to the painful joints.

All patients on arrival at Mineral Springs Hospital are given a thorough physical examination by the doctor. Full blood-count, blood chemistry, sedimentation rate and urinalysis are done by the laboratory technician as well as an x-ray of the affected part. A basal metabolism test is done on all cases of rheumatoid arthritis. If the doctor finds it necessary from these reports, the patient is immediately started on gold salts (Lauron) which is given weekly over a period of many weeks depending on the case history or until the sedimentation rate is normal. Vaccine is used as well in all cases.

Daily, a medically-trained masseuse and masseur go about the hospital giving passive movement exercises to prevent adhesions of the joints. In the quiescent stage, manipulation of the joints (where adhesions have already formed) is done under anesthetic by the doctor. After this is done a cast or half-cast may be applied to hold the limb in the improved position. Casts are left on for forty-eight hours and then removed for easy exercise and replaced daily. Sandbags are also used in some cases.

When I leave Mineral Springs Hospital I will feel, as does every other nurse, that arthritis is a dreaded disease, a menace to humanity to be fought with the same vim and vigour as is tuberculosis.

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# Employment Policies for Nurse Personnel in Alberta Hospitals

ELIZABETH B. ROGERS

For several years, general duty nurses have been dissatisfied with their rates of pay and the Alberta Association of Registered Nurses has been trying to get the co-operation of the Associated Hospitals of Alberta to have this matter remedied. At the annual meeting in Calgary in March, 1945, a resolution was passed by the General Nursing Section that minimum salaries for general duty nurses should be established in accordance with the recommendations regarding salaries approved at the Executive Committee meeting of the Canadian Nurses Association, Nov. 20, 1943, namely: that general duty nurses "living out" be paid a salary of $1,200 per annum for the first year of service, $1,260 for the second year, and $1,320 for the third year, in addition to meals, while on duty, and laundry.

In June, 1945, the Associated Hos-

pitals of Alberta granted an A.A.R.N. committee an interview which resulted in the A.H.A. appointing a committee to assist in drawing up provincial schedules, not only with regard to salaries but, in response to a request from a member of the A.H.A., for hours of duty, vacation, sick leave with pay, hospitalization and superannuation for nurses in Alberta hospitals.

During July, representative nurse committees from all types of hospitals in Alberta met many times to arrange these schedules, then an entire day was spent with the A.H.A. committee after which revisions were made and the schedules sent to both the nursing staffs and boards of every hospital in the province for study, suggestions, and criticisms.

At its annual convention in Calgary, November 14-16, 1945, the Associated Hospitals of Alberta went on record as endorsing the following sections of the proposed schedules:

1. *Salary*:

(a) A minimum salary of $80 per month *with full maintenance* for general duty nurses, or,

(b) A minimum salary of $100 per month *with two meals and laundry* for general duty nurses not in residence.

(c) Salary increments. The principle was approved of paying increments to general duty nurses for satisfactory services and that such increments should bring the salary to a minimum of $100 per month, plus full maintenance, at the end of three years.

(d) Salary for substitute staff nurses. General duty nurses who substitute for a charge nurse when on vacation or because of illness shall be paid an extra $10 per month for so doing.

*Note*: These are the *minimum* salaries that are to be paid. Hospitals have the right to pay as much more as they wish. No salary maximum or ceiling was set.

Minimum salaries for general duty nurses were the only ones definitely stated. The salaries, hours of duty, etc., of other nurses on the staff would have to be stabilized in fair relationship to these.

2. *Hours of duty*: That a working week for all classes of nurses be recognized as consisting of forty-eight hours, exclusive of time for meals.

3. *Vacation*: That at least three weeks' annual holidays with pay be granted all general duty nurses after one year's continuous service, said three weeks to be exclusive of legal or statutory holidays.

4. *Sick leave with pay*: That nurses be given three weeks' sick leave with pay after one year's service.

5. *Hospitalization*: That free hospitalization be given general duty nurses irrespective of whether they live in or out of the hospital.

*Note*: The foregoing stipulated schedules are to act as a floor or basis, with hospitals having the privilege of improving them if they wish.

6. *Superannuation*: That the consideration of superannuation be referred to the incoming Associated Hospitals of Alberta executive committee.

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## Preview

**Many qualities are required in nurses if they are to do their day-by-day work efficiently. One of the most important of these characteristics is maturity — maturity of judgment, of social relationships, of every channel of her existence. All is not lost if any girl does not possess this desirable quality in sufficient degree — it may be developed with thought and guidance. Our good friend, Dr. S. R. Laycock, has outlined what forms maturity should take and how it may be achieved.**

# Interesting People

**Helen Maude Carpenter** has been appointed to the staff of the University of Toronto to serve as a member of the teaching faculty of its School of Nursing. Miss Carpenter has a dual role to play as she is also directing the nursing service of the Department of Health in East York Township. This arrangement results from a project which has been undertaken by the University, the Township, and the Province of Ontario to provide a demonstration centre for teaching purposes for both medical and nursing students. The Rockefeller Foundation is making a small contribution toward this project.

Born in Montreal, Miss Carpenter received her schooling in Vancouver. In 1932, she graduated from the school of nursing of the Toronto General Hospital, and from the public health nursing course at the University of Toronto the following year. She was appointed to the Ontario Red Cross Outpost Hospital at Thessalon and served there for a year. After two years as staff nurse with the Victorian Order of Nurses in Hamilton, Miss Carpenter transferred to the Toronto branch where she was employed first as supervisor, later as assistant director. In 1942, Miss Carpenter received a scholarship from her hospital alumnae and completed the work for her B.S. degree at Columbia University. After one year as consultant in public health nursing with the British Columbia Board of Health, Miss Carpenter proceeded to Johns Hopkins University on a Rockefeller Fellowship and there received her Master of Public Health degree.

This unusually broad and thorough background of preparation fits Miss Carpenter for the stimulating work she has now undertaken. The experiment will be watched with keen interest.

HELEN CARPENTER

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**Margaret A. Wilson** has recently been appointed to the new executive office of business manager of the Parkwood Hospital, London, Ont. Born and educated in Stratford, Miss Wilson graduated from the Woodstock General Hospital. Post-graduate work in radiology brought her recognition from the Ontario Society of Radiologists.

After serving as assistant superintendent of the Receiving Hospital in Detroit for four years, Miss Wilson was appointed superintendent of the Scott Memorial Hospital, Seaforth, Ont., when it was opened in October, 1929. At the time of her recent resignation from that position, after sixteen years of service, a special meeting of the Board was called to honour Miss Wilson with a suitable presentation.

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**Maisie Kathleen Miller** has returned to the Victoria General Hospital, where she served as assistant superintendent of nurses and instructor from 1938 to 1941, as superintendent of nurses. Born in New Brunswick, Miss Miller graduated from the Moncton Hospital in 1925. An inclination for further study started her on a medical career at McGill University. However, she returned to nursing as her life work and joined the staff of the Moncton Hospital serving at var-

ious times as night supervisor, ward supervisor, and part-time intructor, interspersed with four years of private duty. In 1937, Miss Miller was awarded the Florence Nightingale Memorial Fellowship offered by the Canadian Nurses Association. She specialized in hospital and school of nursing teaching and administration during her year at Bedford College, London, Eng. In 1941, Miss Miller was appointed assistant to the executive secretary of the C.N.A., and served in National Office for nearly two years. During this time, she gave assistance in connection with the work of the National Emergency Adviser, particularly in the compilation of survey data.

Miss Miller has taken a prominent part in both the provincial and chapter association work in New Brunswick and Nova Scotia. She is a member of the Women's Canadian Club and the Business and Professional Women's Club. Her association with friends made during the University of London days is continued in her affiliation with the Old Internationals' Association. We will remember that one of her favourite hobbies is cooking the next time we are looking for meals in Halifax. Hearty good wishes for the success of the school of nursing under her ministrations!

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**Dorothy Macham, A.R.R.C.**, who graduated from the Women's College Hospital, Toronto, in 1932, has assumed the duties of superintendent in that hospital. Miss Macham was one of the first group of nurses to go overseas, enlisting with the R.C.A.M.C. in September, 1939. In June, 1940, she joined with No. 15 Canadian General Hospital, was in England until the fall of 1943, and in Sicily and Italy until 1944. She was made an Associate of the Royal Red Cross while in Sicily. In July, 1944, she went to France with No. 8 C.G.H. and was matron of this hospital in Belgium and Holland. She served as matron of No. 18 in England before her return to Canada. Major Macham was the first sister in charge of the first plastic surgery unit in the Canadian Army .

*R. Norwood, Halifax*

MAISIE K. MILLER

**Marion J. MacKinlay**, a graduate of the class of 1943 of the School of Nursing, University of Toronto, has been appointed superintendent of the Scott Memorial Hospital, Seaforth, Ontario.

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The members of the nursing staff of the Provincial Department of Public Health, Saskatchewan, are very proud of the fact that their director, **Elizabeth Smith**, has been awarded a Rockefeller Scholarship which is enabling her to study public health nursing developments in the United States and eastern Canada. Miss Smith will be away from her office for three months.

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**Laura Holland, C.B.E., R.R.C.**, wise counsellor to nurses and social workers

ELIZABETH SMITH

LAURA HOLLAND

alike, has retired from active work. Born in Montreal, Miss Holland received her education at St. Mildred's College, Toronto. The career which was mapped out for her was as a concert pianist and her musical gifts were such that great things were predicted for her. However, she deserted this to enter the school of nursing of the Montreal General Hospital, whence she graduated in 1914. Following a year of private duty, Miss Holland joined the C.A.M.C. and served with distinction in England, France, Salonika, and Lemnos.

On her release from the army in 1919, Miss Holland enrolled at Simmon's College School of Social Work, Boston, winning her social work diploma. Her first appointment was to the social service department at the Montreal General Hospital. From there, she went to the Ontario Red Cross Society as organizer of outpost hospitals — a service for which she later received the honour of being made a Commander of the British Empire. In 1923, she was appointed manager of the Welfare Division of the Department of Public Health, Toronto. In 1927, Miss Holland was persuaded to undertake the re-organization of the Children's Aid Society in Vancouver. Four years later she was called upon to serve provincially as deputy superintendent, later superintendent, of Neglected Children. Her vision and foresight built strongly and wisely. When she became supervisor of the B. C. Welfare Field Service she planned for the developments which have made this service outstanding in Canada. Latterly she has been adviser to the Minister on Matters of Social Welfare Policy.

Despite her preoccupation with social work, Miss Holland has never deserted her first love, the nursing profession. Throughout the years she has played an active role in the developments of the Registered Nurses' Association of British Columbia. Her wise counsel helped to lay the foundations for the Placement Service, for the development of the nurses' associations into functioning districts and chapters, and many other lines of activity.

Beyond her record of achievement in nursing and social work stands the kindly and gracious lady who was never too busy to listen to and to help in the solution of problems. Her unselfishness, her high ideals, and her ability to understand have merited her a place in the deep affections of all who know her. We wish her great happiness in the years that lie ahead.

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After nearly twenty-five years of service as superintendent of nurses at the Victoria General Hospital, Halifax, **Gladys Ethel Strum** has retired. A native of Nova Scotia, Miss Strum traces her ancestry back to the very early pioneers who helped to establish the province two centuries ago. Before commencing her nursing career, Miss Strum taught school in Nova Scotia and Manitoba. Graduating with the 1919 class at the Royal Victoria Hospital, Montreal, she spent several months there as night supervisor. In 1920, she joined the staff of the Victoria General Hospital as assistant superintendent and instructor. In 1929, Miss Strum was awarded a Rockefeller Scholarship on which she spent three months studying nursing developments in the United States.

For many years, Miss Strum held prominent positions in the provincial association. She was also active in the

work of the Mental Hygiene Association in Nova Scotia. She has the distinction of being a charter member of the Halifax Branch of the Soroptomist Club and, in her busy life, found time to belong to the Women's Canadian Club and the Business and Professional Women's Club. For a number of years she was an associate members of the Halifax Ladies Musical Club and the Community Concert Association. This wide diversity of interests will provide a full measure of happiness for her in her retirement.

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**Lucy Hodgkins,** who has been matron of the Chilliwack Hospital, B. C., since 1927, has retired. Born and educated in England, Miss Hodgkins graduated from the Royal Infirmary, Manchester, in 1919. Two years later she obtained her C.M.B. through the City of London Maternity Hospital. After considerable experience in Britain, Miss Hodgkins came to Canada in 1924 and for three years worked as a staff nurse at Chilliwack before becoming matron.

As soon as she can get passage, Miss Hodgkins hopes to go back to England on an indefinite visit to her family. Good luck go with you and pleasant days wherever you may be!

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**Mary Dickson Patterson** has resigned as school nurse in Amherst, N. S., after twenty-two years' active association with the work. Born and educated in Nova Scotia, Miss Patterson went to the New Hampshire State Hospital to receive her nurse's training, graduating in 1913. She had the distinction of being the first public health nurse appointed by the City of Calgary. When her health broke, Miss Patterson returned to Nova Scotia and was hospitalized for a year. She served as assistant matron in the Nova Scotia Sanatorium, then was two years with the Massachusetts-Halifax Health Commission before assuming her duties in Amherst.

LUCY HODGKINS

Miss Patterson is well supplied with hobbies to keep her company. An ardent historian, she loves antiques and handicrafts. For out-door activity she will turn to gardening. We wish her full enjoyment and good health following a job well done.

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## Obituaries

**Mrs. Ida May (Davis) Callison** died died in Fallowfield, Ont. Mrs. Callison was a graduate with the class of 1908 of the Lady Stanley Institute for Trained Nurses, affiliated with the County of Carleton General Protestant Hospital, now amalgamated with the Ottawa Civic Hospital.

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**Gladys Helen Fitzgerald,** who graduated in 1930 from the Belleville General Hospital, died suddenly at the Rideau Military Hospital, Ottawa. Miss Fitzgerald was engaged in private duty until the outbreak of war when she volunteered for service in South Africa. On her return to Canada, she remustered with th R.C.A.M.C. and was posted to the Rideau Military Hospital. Her sister, Lieut. (N/S) Marguerite Fitzgerald,

has been serving on the Canadian hospital ship, *Lady Nelson*.

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**Doris Gale**, a graduate of Chipman Memorial Hospital, St. Stephen, N. B., died there recently. Miss Gale was chosen to accompany the late Mrs. James Roosevelt to Hyde Park after her last visit to her summer home on Campobello Island, and she remained in attendance until Mrs. Roosevelt's death.

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**Jean Murray Kellock** died in Toronto recently after a brief illness. Miss Kellock was a graduate of the Kingston General Hospital and took post-graduate work at the Royal Victoria Hospital, Montreal, where she was night superintendent for a time. For some years she served with Home Mission hospitals, under the auspices of the Presbyterian Church, in Yukon and later in northern B. C. where she was one of the few white women settlers. She was also matron of a hospital in Ethelbert. Miss Kellock continued active in nursing until four years ago when she retired at the age of eighty years.

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**Henrietta A. Mackay**, who was a member of the first class of nurses to graduate from the Jeffery Hale's Hospital in 1904, died in Quebec. She was a successful private duty nurse until she enlisted with the C.A.M.C. in 1914, the first English-speaking Quebec nurse to volunteer. She served with No. 1 General Hospital in France. On her return to civilian nursing she joined the Donnacona Paper Mills Hospital. In 1925, she attended the meeting of the International Council of Nurses in Helsingfors. Ill health forced her retirement from nursing activities several years ago.

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**Minnie B. McClelland**, a native daughter of Nova Scotia, died recently. She graduated from the Massachusetts General Hospital and spent most of her professional life in the United States.

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**Mary Agnes Morgan**, a graduate of St. Joseph's Hospital, Toronto, died suddenly. For the past few years Miss Morgan had been nursing at Wesley Memorial Hospital in Chicago.

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**Mrs. Margaret (Stirling) Parkinson** died in South Africa. Graduating from the Toronto Western Hospital, she specialized in the x-ray department and, in 1942, volunteered for service with the group of nurses who answered the call to assist in South Africa. She continued to nurse following her marriage to Robert Parkinson, who was with the Royal Navy. She was on duty in the Roberts Heights Military Hospital when she was stricken with poliomyelitis. She was accorded a full military funeral.

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**Alice Gertrude Powter**, a graduate with the class of 1904 from the Montreal General Hospital, died recently in Montreal.

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**Ilene Stowe**, who graduated from the Toronto Western Hospital in 1928, died recently in Toronto.

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**Alice Thomson**, a graduate of the Toronto General Hospital in 1921, died recently from a heart attack. Prior to joining the staff of the Department of Public Health in Toronto in 1924, Miss Thomson served with the Victorian Order of Nurses. During her twenty-one years with the Health Department she was for four years supervisor of the Moss Park district, and in 1929 was appointed supervisor of the maternal and child welfare division.

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**Anna E. Valens**, a graduate of the Brandon General Hospital, died in Los Angeles last autumn. Miss Valens practised nursing in Canada for two and one-half years before going to California in 1910. She served overseas as a member of the United States Army Nurse Corps in World War I. As director of the out-patient department of the Children's Hospital in Los Angeles from 1919 to 1939, Miss Valens made a valuable contribution to the nursing care of the community and to the progress of nursing.

# Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

## General Meeting — 1946

The date of the Twenty-third General Meeting of the Canadian Nurses Association has been announced in previous issues of the *Journal*, and although July first may be a holiday for the general public, the nurses of Canada will celebrate by attending the opening sessions of a four-day convention.

Apart from the two panels, which are scheduled for July first and second, one of the special items of interest at this general meeting will be the report of the Legislation Committee, which has been working so strenuously on the complete revision of the Constitution and By-laws. Every nurse in Canada will be concerned with this revision and its effect on the organization in general. The report of the Labour Relations Committee will also be of vital interest.

It is hoped that arrangements for special speakers on the panels, and for the Mary Agnes Snively Memorial Lecture, will soon be completed so the names may be published in the next issue.

The Committee on Nursing Education is being assigned a complete morning session. This important committee will be dealing with some of the most vital questions concerning the future of nursing, and every nurse will want to be present at this session. Watch for further announcements in the *Journal*.

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## Nurses' Relief Campaign

A letter received at National Office from Miss C. H. Menalda, president of the Netherlands Nurses' Association, reads as follows:

*Amsterdam, January 3, 1946.* I am only too glad to let you know that the clothing which was sent to us by the Canadian Nurses Association has safely arrived.

In the name of the nurses of the Netherlands I want to thank you most heartily for your generous donation. It is quite impossible to give you an impression of our thankfulness for receiving so much; we can hardly believe that it is a reality. We are so happy to be able to disperse all those useful articles among our nurses, who need these things so badly.

Would you be good enough to transmit to the nurses of Canada the expression of our warmest gratitude? Please do tell them also that the sympathy of our colleagues over there is most stimulating after all we have gone through. I can assure you that we shall never forget all you have done for us.

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## Extension of Time Limit for Candidates for University Courses in Nursing

A considerable number of nursing sisters retired from the armed forces have been unable to gain admission to university courses for graduate nurses because the classes were already filled to maximum capacity. It is not anticipated that all the candidates can be accommodated in classes even in the next academic year, and, therefore, it may not be possible for such candidates to commence training within the prescribed period of fifteen months following discharge.

Therefore, nurses who make application for university training in nursing

within the original time limit, will be granted an extension if they can demonstrate their inability to commence training on the grounds that the classes are already filled to capacity. A letter should be obtained from the university stating that they are acceptable, and will be admitted for training as soon as facilities permit. It should be emphasized, however, *that application for training must be made to the Department of Veterans Affairs within a time limit of fifteen months after the time of discharge*, and preferably as soon as possible following discharge. (*Signed*) E. L. M. Burns, Director General of Rehabilitation.

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## Royal College of Nursing

It is interesting to note that the Advisory Service of the Royal College of Nursing has been set up to meet the need of every demobilized nurse. They have presented an attractive leaflet giving information and practical advice and showing the enormous scope for nurses with a fresh outlook and determination to create and maintain new high standards in their work.

A Liaison Committee has been set up between the Royal College and other professional bodies on matters of joint interest, namely: (1) The British Medical Association to co-operate in the formation of a Liaison Committee; (2) the Royal Society of Medicine to provide fifty nurses in the London area to serve on viewing panels for the assessment of medical films from the point of view of medical education; (3) to appoint a representative to serve on the Council of the Queen's Institute of District Nursing.

A memorandum on vocational guidance and selection tests for the nursing profession was submitted to the General Nursing Council.

It will be noted that the Nursing Reconstruction Committee is unanimously against the frequent pre-war practice of entering candidates for the test from the hospital; the standard of general education has been such that sister tutors have had to spend time in giving classes in general education subjects, instead of concentrating on the professional training.

Because of the heavy wastage rate, the recruitment target mounts progressively higher every year, and is now over twenty thousand. It is imperative that wastage be minimized and a greater economic use be made of hospital staff generally. In order to do this, the whole conception of hospital staffing should be overhauled. Many types of personnel are concerned in the day to day care of patients — trained and student nurses, assistant nurses, orderlies and domestic staff. Full use should be made of every type, and recruits for training for the State Register and Assistant Nurses' Roll selected on the most modern lines. No candidates should be accepted for training in a particular field without reasonable chance of their making good. The result would be that the number of nurses required would be greatly lessened and the position stabilized.

In the place of the old form of Educational Test, the College recommends a series of tests designed to show whether the candidate has the mental and practical qualities required of a nurse.

The tests should be carried out on a national basis and be specially devised, in conjunction with an expert body such as the National Institute of Industrial Psychology, to assess (a) the scholastic aptitude; (b) the technical aptitude and, as far as possible, (c) the personal suitability of candidates for the nursing profession. Candidates would be graded according to the results of the test, e.g.: (1) recommended; (2) conditionally recommended; (3) not recommended, and the matron should have the results of the tests before her when interviewing students. The qualities of character and innate refinement necessary to the nurse are best assessed at the personal inter-

view, and the person who should give that interview must herself be a member of the profession, namely, the matron. She, in turn, would require expert instruction in the art of interviewing and the assessment of suitability, coupled with the confidential report from headmistress or recent employer, should always be the deciding factor in borderline cases with low marks in the selection tests.

Group aptitude tests for nurse training schools should be especially undertaken by experts on the basis of job analysis and must take account of the nurse's very special requirements, in which visual manipulation and intellectual factors all play a part.

During the war, modern methods of personnel selection have been increasingly used in the Services. Under the new methods of selection where the failure rates for one type of class previously varied between 30 per cent to 13 per cent, they were reduced to 0, while in another, where previously between 70 per cent and 50 per cent obtained less than 60 marks and were relatively poor at their work, the figures were reduced by the new methods to between 28 per cent and 12 per cent. These excellent results were obtained by three stages:

1. *Voluntary principle.* The candidates were told what kind of work they would have to do, what kind of training they would have to take, what pay they would get and so on. The experts had to find out whether the individual was really interested in the work and wanted to do it.

2. The candidates were given various tests to ensure that they had the intelligence and aptitude for the work.

3. The candidates were interviewed by psychologists well-informed about the tasks they would have to perform.

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## The Shortage of Nurses

The nurse shortage is one of the gravest facing many nations today. Word comes from Great Britain that hospitals all over the country are closing down wards because of the lack of nurses. The Minister of Health, Mr. Aneurin Bevan, has launched a recruiting drive for at least thirty-four thousand additional nurses. From the editorial page in *Hospitals* magazine, December and January numbers, we quote the following:

Acute personnel shortage during the war and since has been the most serious problem facing hospitals. The first three months of demobilization following Japan's surrender brought no substantial relief to hospitals suffering from an acute shortage of nurses and other personnel. Statistically, 30.6 per cent reported their shortage of graduate nurses more acute, 37.2 per cent reported less acute, 32.2 per cent reported no change.

The subject of personnel practices and the shortage of nurses appear to be closely linked and point again to the imperative need for nursing and hospital associations to work together on setting up desirable personnel policies and practice. The time is now.

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## International Nursing Bulletin

Information has been received from the headquarters of the International Council of Nurses to the effect that up to January 31, 1946, only forty-nine nurses or institutions in Canada had sent in their subscriptions for this very interesting and useful little publication. Mention of the revival of the *International Nursing Bulletin* was made in the October, 1945, issue of *The Canadian Nurse*.

Every instructor of history of nursing

needs to receive a copy of this *Bulletin* if she is to keep herself informed of current developments in world-wide nursing. What is happening today will be historical tomorrow. Similarly, no instructor in nursing trends or professional problems can give a true picture of present-day trends if she is not aware of the international picture.

The *International Nursing Bulletin*, a quarterly publication, is now available at a subscription price of $1.00 per year from the International Council of Nurses, 1819 Broadway, New York City 23. (Make cheques payable to I.C.N.) The January, 1945, number contained a report of Miss Effie J. Taylor's visit to London and news about nursing in China and the European countries. Miss Anna Schwarzenberg, the Executive Secretary of the I.C.N., who is now in Europe, will send her observations on the nursing situation in the countries she is able to visit for the April number of the *Bulletin*.

All subscribers who send in their money by April 1 will receive the January number so that their files of the *Bulletin* may be complete.

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# Opportunities for Nurses with the D.V.A.

Through this channel, the Treatment Services of the Department of Veterans Affairs hopes to keep the nursing profession conversant with its organization and activities, as well as give some idea from month to month of the nursing needs, and the extent of the service being carried by this Department.

The *News* this month is that re-organization plans in the nursing service are under active consideration, including a related salary increase for the positions of Matron and Supervisors. It has been indicated that the necessary revisions may be expected in order to meet the present emergency.

The following temporary classifications have been approved to meet the present emergency:

### District Positions

*Grade* 3 *Matron* — Matron in charge of hospital over 700 beds. Salary $2700

*Grade* 2 *Matron* — Matron in charge of hospital of 200-700 beds. Assistant to Matron in larger hospitals. Salary $2400.

*Grade* 1 *Matron* — Matron in charge of institution of 50-200 beds. Night Supervisor in hospitals over 700 beds. Assistant to Matron in hospitals over 200 beds. Salary $2100.

*Charge Nurse* — Nurse in charge of a designated section of a hospital, i.e., ward or small department or specialty division, selected by the Matron and Medical Superintendent, on a temporary basis after having been referred for approval to Head Office and Civil Service Commission. Extra allowance of $10 per month over the hospital nurse salary range, while so acting.

### Hospital Nurse

*Grade* 3 — Operating Room nurses with six months' previous satisfactory Operating Room experience. Nurses with specialty post-graduate courses and training, i.e., T.B., Orthopedics, Psychiatry, Neurosurgery, Plastic Surgery. Salary $1740 while so employed in a Department Hospital.

*Grade* 2 — Nurses with good nursing preparation and wide experience covering a period of over two years preferably in more than one hospital, but not necessarily specialized in any one branch of nursing. Salary $1560.

*Grade* 1 — Nurses with limited nursing preparation as to place and time of less than two years' duration. Salary $1380.

### Nursing Bulletin

The second edition of our *Nursing Bulletin* will be published shortly, and it will contain the specific duties, qualifications, and salaries for each of the above position classifications. It will contain all the regulations concerning the employment of nurses, laid down by the Civil Service Commission, as well as specific reference to the cost of living bonus, the room and board charges for nurses living in residence, as well as the 5 per cent superannuation and retirement deduction.

### The D.V.A. Needs Nurses

There is still a very urgent need for nurses in the Departmental Hospitals, especially those with tuberculosis and psychiatric training, as well as Grade 1 Matrons. The greatest need is in the Districts where we are opening new hospitals, particularly in Montreal District. Your interest is invited, and inquiries may be made of the matron in charge of the nearest hospital of the D.V.A., or inquiry made direct of the Matron-in-Chief, D.V.A., Ottawa.

It is hoped that by early summer sufficient nurses will have joined our ranks to enable us to establish the 44-hour week, and eight-hour day in all of our hospitals. However, these things are naturally only possible in the hospitals where there is a sufficient staff.

As everyone realizes, re-organization in a Department with positions for practically two thousand nurses is not achieved overnight, nor without delays and set-backs. However, if the new people coming in will join with the same determination and perseverance that the presently employed nurses have demonstrated, we may still come through this period of re-organization with flags flying, and with our veteran patients cared for as we feel they should be.

Selections are being made continuously. The District Offices of the Civil Service Commission established in the capital cities of the provinces of Canada are conducting competitions for selection of qualified candidates, and appointments are made from the lists published as a result of these competitions. Next month we will tell you about some of the new arrivals in the Department of Veterans Affairs.

Agnes J. Macleod,
*Matron-in-Chief for Director General of Treatment Services, Department of Veterans Affairs.*

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## Post-Graduate Work in Canada

In the July, 1945, issue of the *Journal* we published a list of post-graduate courses in university and hospital schools of nursing and added experience arrangements in hospitals. At that time we invited additions to the list, and are now glad to publish the following information:

The Saint John Tuberculosis Hospital, East Saint John, New Brunswick, offers a three months' course in tuberculosis nursing. Further information can be obtained from Miss Florence E. Coleman, Superintendent of Nurses.

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## Preview

**We are accustomed to think of the student nurse as a learner. That she should also be a teacher is the premise developed by Mother Albert who proves her case in a very convincing manner in the next issue.**

# STUDENT NURSES PAGE

## Biliary Obstructive Cirrhosis

EVELYN GAY

*Student Nurse*

*Mack Training School, St. Catharines, Ont.*

Mrs. A, age 47, a Russian housewife, was admitted to the hospital during September suffering apparently from severe jaundice. She was a patient and long-suffering individual who didn't complain, but I believe that she suffered much pain in spite of the fact that she never mentioned it. During the week previous to her operation her temperature ranged between 98° and 100°. The doctor ordered a low fat, high carbohydrate, high protein diet, plus as many sugared drinks as she could tolerate. In ordering this diet, the doctor was thinking of protecting the liver as well as looking forward to a time, post-operatively, when the intake of carbohydrates and proteins would be very low. Then, this reserve store of glycogen in the liver would stand in readiness to supply the need. The high carbohydrate would also help to balance up the caloric intake, which was lowered by a decrease in fats. It was a struggle for her to eat anything at all, but she did her very best to please us. She had no difficulty in drinking the fruit juices.

In preparation for her operation, and also in view of the fact that she was so exceedingly jaundiced, she was given bile salts and vitamin K. The absence of bile in the intestines caused a poor intestinal absorption of fats which contain vitamin K. This vitamin is necessary for the production of prothrombin, and a bleeding tendency is associated with a low prothrombin level. She also received a complex vitamin preparation called *Multicebrin*.

A plain film was made of her abdomen. This was normal. A barium meal showed no filling defect in either the stomach or the intestines.

Her blood was typed and a number of her children and several friends were typed also, so that they might be ready to give blood for a transfusion.

Preparatory to her operation, Mrs. A received 1000 c.c. of blood plasma and 500 cc. of glucose and normal saline. Her hemoglobin was 84 per cent and the red blood count stood at 4,040,000 per cubic millimeter. Daily specimens of urine were sent to the laboratory for bile and urobilin examination; also, whenever obtainable, a specimen of feces for occult blood. The feces when examined showed an absence of bile which indicated a probable obstruction of the common bile duct.

About the fifth day her skin, which was already very irritable, broke out in large red wheals, principally on her back and thighs. The obstruction was causing the bile to be absorbed by the blood stream and the bile salts, which are very toxic, were causing this skin condition. The angry redness of the wheals combined with the yellow of the jaundice made her skin a bright orange colour.

Frequent bathing and powdering seemed to give her the most relief.

The whole week of waiting she endured most cheerfully, never complaining. I think that she was so inured to suffering that it did not occur to her to complain or question any hardship. She had had twelve children and from what I could gather, had raised them on a very small income, so she was well acquainted with hardships. Her gratitude over just the simplest routine nursing attentions made it a pleasure to do everything possible for her comfort.

The day preceding her operation she was given abdominal preparation. Before bedtime, seconal and delvinal were given to ensure a quiet night's rest. At nine o'clock, the morning of her operation, hyoscine gr. 1/150 and seconal gr. 1½ were given. At ten o'clock she was taken to the operating-room, seven days after her admission to the hospital.

The report from the operating-room was worded in this way: "On opening the abdomen by a right transverse incision, the gall bladder was found to be collapsed, and the distal duct stem small. The hepatic duct stem was also collapsed. These findings placed the obstruction at the termination of the two large interhepatic ducts. Because a small catheter could not be passed into the duodenum, the latter stricture was opened and a small non-obstructing polyp was removed from the ampulla. The duodenum was closed and the upper ductal system explored. This revealed that a probe could not be passed into the left hepatic duct, but passed slightly into the right. Cholangiograms were made on the table which showed that no dye entered the left duct but some entered the right." The surgeon placed a "T" Tube in the right hepatic duct and the abdomen was closed. The operation took three hours.

Mrs. A was conscious on return to the ward. Her colour, pulse, and respirations were all of good quality. Somewhat later in the afternoon an intravenous of blood plasma was started to combat surgical shock. During the following twenty-four hours approximately 1000 cc. of blood plasma and 2000 cc. of glucose and normal saline were received. She was allowed only sips of water. To overcome dryness, her mouth was rinsed out frequently and plenty of glycerine and lemon juice was used on her lips to prevent them from cracking. Twice during the first night she needed morphine to lessen her pain and give her an opportunity to rest and to combat shock. She seemed to be more jaundiced than before the operation. She perspired very profusely which meant that she acquired almost constant care. It was necessary to change her sheets three or four times during the night and give her alcohol rubs. The orders were to turn her frequently so it usually meant that every time we turned her, we rubbed her back.

The following day Mrs. A had 500 cc. of whole blood, followed by glucose and normal saline. The glucose and normal saline were continued for almost two more days, during which time around 5000 cc. were administered.

The patient had no difficulty in voiding and the bile drainage was adequate. Every day a specimen of urine was sent to the laboratory for bile and urobilin tests and every other day blood was sent for an icteric index. The presence of bile in the urine usually indicates an obstruction. Mrs A's urinalysis proved that bile was present in every specimen until just before her discharge when there remained only a faint trace.

Definite conclusions can be drawn by determining the quantity of urobilin in the urine. A van den Bergh test on the second day resulted in an immediate direct reaction which the laboratory technicians interpreted as meaning that the bilirubin was being excreted by the liver, but was being re-absorbed into the blood stream without entering the intestines. The normal amount of bilirubin in the blood is 0.2 to 0.8 milligrams in 100 cc. of blood. On the average, a test showing

2.0 milligrams or above indicates jaundice, but Mrs. A's test showed 3.0 milligrams to 100 cc. of blood. A repeated icteric index test showed a rise after the operation. This test measures the intensity of the bilirubin and gives the degree of jaundice. The normal is around 2.5 to 5.0; Mrs. A's tests ran 28, 49, 40.

About the third day the patient became distended. Eserine and pitressin were given to increase peristalsis and help expel some of the flatus. Eserine gr. 1/150 and pitressin, half a cc., were given, followed in half an hour by a 1-2-3 enema. These measures proved to be effectual in obtaining relief. It wasn't until the fifth or sixth day that it was necessary to repeat the enema to obtain relief. The doctor ordered a light cradle which gave her much more relief in combatting the gas pain than the linseed poultices. The heat cradle gave excellent results, but we had to be much more attentive in keeping her dry for she was continually drenched in perspiration. A pressure sore developed on her back. Cod liver oil and vaseline plus constant attention relieved this. Again on the tenth day she became very distended. This time prostigmine seemed to give her relief.

Mrs. A was a very co-operative patient in all respects with one exception. She just couldn't seem to eat. She took her fluids well, but seemed to lack any appetite. We endeavered to make things attractive and her family did their best to tempt her, but all to no avail. She had been returned to the high carbohydrate, high protein, low fat diet soon after her operation. Her appetite showed no signs of improving until the last few days when she was getting out of bed.

Mrs. A had very little sedation. Seconal and delvinal were most effective in helping her obtain a good night's rest. Towards the end of her hospitalization, she became very restless. Phenobarbital, one-half grain three times a day, seemed to help her relax and curbed her restlessness.

When Mrs. A was discharged her jaundice had almost disappeared and she felt immensely improved. Although her prognosis was poor her immediate condition had improved. During the operation a biopsy of both lobes of the liver had been taken. The pathological report of the examination was portal cirrhosis of the liver, but the clinical diagnosis was cancer of the left hepatic duct with much surrounding inflammation.

Her hospitalization amounted to twenty-seven days. Two weeks later she returned for an x-ray of the gall bladder and liver. The plate showed some filling defect in the hepatic ducts.

A follow-up several months afterwards showed that the jaundice had completely disappeared, her fatigue had disappeared, her appetite was good, and she had gained weight.

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# Letters to the Editor

*Canadian Nurses in Germany*

How would you like to have a few notes from Germany (British Zone) about the Canadian nurses I have on my staff? On a field trip which I made just before Christmas I visited Lilian Rankin, who is Field Nursing Supervisor in the Brunswick area. She lives in a very charming little town called Wolfenbuttal. Her area has a fairly concentrated DP population and she has about nineteen UNRRA nurses under her supervision. From Wolfenbuttal I proceeded to Osterode which is a little town south of Hanover in the Hartz Mountains. There I visited Frances Pearl, who is Field Nursing Supervisor for that area. I have forgotten the number of Assembly Centres she has but it is somewhat less than

the Brunswick area. The distances are much greater since it is in the mountains (or what are termed mountains in this country) and transportation is more difficult.

Edna Osbourne is the Senior Nurse in a large Assembly Centre in a place called Fallingbostel. This is near Belsen and about sixty miles south of Hamburg. At the moment she has five UNRRA nurses working with her and the population of the Camp is about eighteen thousand. She is working with one of our two Canadian doctors—Dr. MacNeil. Further north, Jean Watt is Field Nursing Supervisor, situated at Schleswig, the district near the Danish border. Mary Wade is one of her nurses. Mary has been at Niebull, which is quite near to the Danish border. She has been working in an Assembly Centre where there is no UNRRA doctor and has been doing a very fine job. She attends the Medical Conferences and has all the information needed at her fingertips when requested by the Senior Medical Officer for the District. In a week or so she will be moving to the Isle of Sylt.

Mary Dunn is in an Assembly Centre of about fourteen thousand DPs about fifteen miles from Hamburg. She is going ahead organizing the public health nursing activities in a very fine manner. Marjorie Lownds is in the town of Neumunster which is between Hamburg and Kiel. Neumunster was a railway centre and you should see the station and the yards now! It is an extremely fine example of precision bombing! Janet Vanderwell and Jean Lazecko are in the Glynn Hughes Hospital at Belsen. Actually the word "Belsen" is obsolete now and we should be using the new name "Hohne". However, when we use that the mail is returned with "address unknown" marked. The Glynn Hughes Hospital was the first UNRRA commitment in this zone. We have twelve nurses there who are acting in a supervisory capacity over the German staff. The physical set-up of the hospital is very fine since it was a former hospital for German officers, Belsen being the centre of the training of the Panzer divisions.

Germaine Bernardin and Norah Madden were the only two Canadian nurses I was not able to contact personally last month. Miss Bernardin is at Siegen down in the southern part of our zone. From her supervisor I understand that she also is doing a very fine piece of work. Miss Madden is in Oldenburg,

*Copenhagen fishmarket.*

which is the HQ for the Canadian Army in Germany. She is enjoying her work very much in an Assembly Centre of Baltic DPs.

The remaining Canadians are Norena Mackenzie and myself. Norena is very busy with the Nurses' Aides courses which we have started. Just as soon as one of these courses is completed we are going to write an article for you. We have three courses going now and within the next two weeks we hope to have two or three more organized. We stated our purpose as two-fold—(1) to get extra hands for the winter program and (2) to interest young girls in the nursing profession. Our real purpose was the latter. Practically all of our candidates (we have forty-two

*Clearing the debris in Cologne.*

enrolled now) have qualifications which will permit them to enter a school of nursing in there own country. We hope in these six-week courses to give them an interest in nursing so that when they do return home they will enter a school as soon as possible. We were fortunate enough to have on our staff some fully-qualified instructors. Of the three who are teaching now two are Danish and one is from New Zealand. There has been a great deal of interest shown on all sides in these courses and we have more than enough applications to start three more groups. Our chief difficulty is finding suitable centres in which to give the instruction.

—LYLE CREELMAN

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*A Repatriate from Hong Kong*

I left Hong Kong on September 22 in the escort carrier *Smiter* which was oily and rusty but most hospitable. We were a complete novelty to all the ship's company from the cats up and they could not do enough to amuse and make us comfortable. That ship was like travelling in a bus depot, as the empty hangar reverberated night and day to the clashing of steel forms being arranged for a cinema show, or the luggage being dragged about by what I presume were the trucks used for shifting the absent planes. Then there was the "Voice that breathed" (full blast) with instructions or entertainment. We picked up two hundred marines at Sabang, with a jeep. They didn't think much of the "Voice" and used to collect below its main point of emission and sing in chorus against it. They also took command of the eight children we had aboard. They drilled them with rifles bigger than the children, ran them up and down in the jeep, and fed them generously on ice cream and sweets until the suffering mothers protested.

I was in a large cabin with about fifty nursing sisters and one poor little wife with lumbago. At 6:30 we were awakened with the Navy's reveille—"Wakee, wakee, wakee. Arise and shine. You've had your time and I've had mine. Roll and stow"— and other words to the same effect. The water was turned on for an hour and a half. There were only three showers available for all of the women aboard. The nursing sisters began rising and queueing for the showers at 5:30 a.m. Then they would leap heavily back into bed. About half an hour later they leapt out again and began offering one another tea out of "thermi." I used to get up when the first bunch had got well into their queue, steal into the small, adjoining cabin in which two of my friends were lucky enough to be berthed. I washed in their hand-basin in water saved overnight. Then I would go up to the flight deck which I would have all to myself at that hour, and walk about, enjoying the light of the stars and the moon. I didn't dare go near the blunt end for fear of being blown off and it was a struggle to get up to the sharply-pointed bow. When I got there I had to hold tightly to the chain to keep my balance.

Our days were spent, between huge meals, sitting on the sponsons out of the sun (but not the wind), knitting the wool the Australian Red Cross had presented to us. At Colombo, we left the *Smiter* and were warmly welcomed by the Red Cross and the Wrens. They offered us food, baths, shampoos, manicures, make-up, and good second-hand clothes to supplement those the Australians had already given us. We stayed with the Wrens for two days and were sorry to leave them. Their bath-house was closed for only two hours out of the twenty-four and you have no idea how much it meant to us to be clean, with the first unrestricted water we had enjoyed for years.

The rest of the trip back to England on the *Empress of Australia* was rather like being on a Sunday school picnic. The boat was crowded so you had to elbow your way to the side, peer between boats, and lean over the double rail to realize you were at sea. At Suez, the Red Cross again took us to its bosom and fitted us out with winter clothes. I am daily more and more grateful to them for their kindness, particularly for two pairs of strong, sensible, broad-heeled shoes made of leather, not blotting paper.

Have you ever been truly seasick? If so, you will believe me when I say I died three times in the Bay of Biscay! I found it a long painful way up again on being recalled to life by busybodies.

I can look back on the life in the internment camp in Hong Kong and be thankful I had a job of sorts to keep me occupied. In addition, I learned the Norwegian language. Viewed calmly, and impartially, from this distance there are many things that stand out in almost comic relief though at the time they were continual sources of annoyance. Such things tried us as, the water being turned off

for two days in three, even for a time, for four days in five; the electricity being abolished entirely, with a complete blackout all last winter; every last sentry having to be bowed to and a lot more unnecessary and, at the time, intolerable grievances. Every time there was a new grave dug in the cemetery, after the last victim had been buried (htere was only one coffin, with a sliding bottom) we would wonder who would fill that hole and hope it would not be our turn. Many a time we pased around the compound after dark to keep warm in the winter. As we watched the moon rise, we would wonder if we were to spend the rest of our lives doing that. We had plenty of books and fresh air and a splendid vista of the island to console ourselves with when the rice was inadequate, the greens uneatable, and we had to pick up stray sticks for a fire to boil water. There were a lot of good people there and I made a few real friends who I never would have encountered had it not been for this experience. Thank goodness it is over!

—CONSTANCE MURRAY

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# Book Reviews

**Principles of Psychology for the Basic Course in Nursing**, by Rev. J. Edward Rauth, O.S.B., Ph.D. and Sister M. Maurice Sheehy, R.S.M., R.N., Ph.D. 200 pages. Published by The Bruce Publishing Co., 540 N. Milwaukee St., Milwaukee 1, Wis. 1945. Price $2.00 (in U.S.A.).

Written by faculty members of the Catholic University of America, the material for this text is derived from their experiences in instructing classes of student nurses. In their preface, the authors emphasize the fact that the book contains only the minimum of formal psychology essential for students of nursing. There appears, however, to be a very wide range of topics touched upon with too little explanatory matter. For a student with no previous background in psychology, there is a very great deal of factual information to be grasped. The same authors have prepared a handbook which expands the items which are scantily explained. This is stated to be for the instructor's use.

The foreword by the vice-Rector of the University indicates the points which differentiate this text from others which are available. It is his belief that a mechanistic psychology, a "psychology without a soul", is incompatible with the instruction which should be given to Catholic student nurses. Throughout the text, therefore, consideration is given not only to physical and mental reactions and behaviour but also to the influence that these may have on spiritual well-being.

A short chapter on mental hygiene, as applicable to the student herself, suggests the importance of developing a "plan of life." Pointers on how to make satisfactory adjustments are included.

The last chapter on Statistics is much too advanced for the average student nurse to appreciate or use. It is difficult to see why it is incorporated in a text of this kind. Few student nurses are concerned with "central tendencies", "variables", "correlation", etc.

An excellent glossary concludes the text.

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**The Dietary of Health and Disease**, by Gertrude I. Thomas. 308 pages. Published by Lea & Febiger, Philadelphia. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 4th Ed. 1945. Illustrated. Price $4.00.

Despite all of the advances in the field of nutrition, there is still a woeful ignorance of the fundamentals of well-balanced diets, the influence of diet on health, and a clamour for health foods with magical qualities. Food rationing and scarcities have accentuated some of

these problems in our own country. In answer to this situation Miss Thomas has thoroughly revised her book, bringing all of the material into line with present-day information. Each of the food constituents — vitamins, minerals, water, etc.—is studied in separate chapters. Tables are included, listing the relative content of the constituents in various foods. A wide range of recipes for invalid diets, meal planning, and food purchasing are included. The latter half of the text is devoted to special forms of dietary—for infants, children, elimination diets for adults, for diabetics and various other diseased conditions. The appendix includes an outline of a 70-hour course in nutrition for the student nurse.

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**Psychology for Nurses**, by Maude B. Muse, R.N., A.M. 467 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 5th Ed. 1945. Illustrated. Price $3.00.

Now in its fifth edition, this well-known text has been brought up-to-date with all the latest thought and theories in psychology. The basic facts have remained the same over the years this text has been in use but there has been a considerable change in emphasis. Greater attention is being paid to the importance of personality interactions. The ability to make social adjustments under trying conditions is necessary in any profession but it is particularly essential that the nurse should understand her own reactions and those of the persons with whom she is so intimately in contact. The text, therefore, outlines carefully what constitutes a well-integrated personality and how it may be achieved. "Personality is the result of a subtle interreaction of three factors: (1) the hereditary specifications; (2) the physical and social conditions under which the individual develops; (3) the personal rejoinder made by the developing individual to physical and social assets and liabilities."

Exercises and problems, review questions, and experiments provide an opportunity for the student nurses to apply the factual material discussed in each chapter. Why people behave as they do, the problems presented by mental conflicts and maladjustments, the extent of individual differences, etc., are fully studied. Students are familiar with tests and measurements through frequent participation. The explanation of how these tests are administered and their usefulness will give the nurse an added interest. The principles of learning are not treated as abstract terms but applied directly to her own problems. Of particular value are the fifteen concise directions on how to study.

Schools of nursing which have used the earlier editions of this text will welcome the new adaptations.

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## R.C.A.M.C. Nursing Service

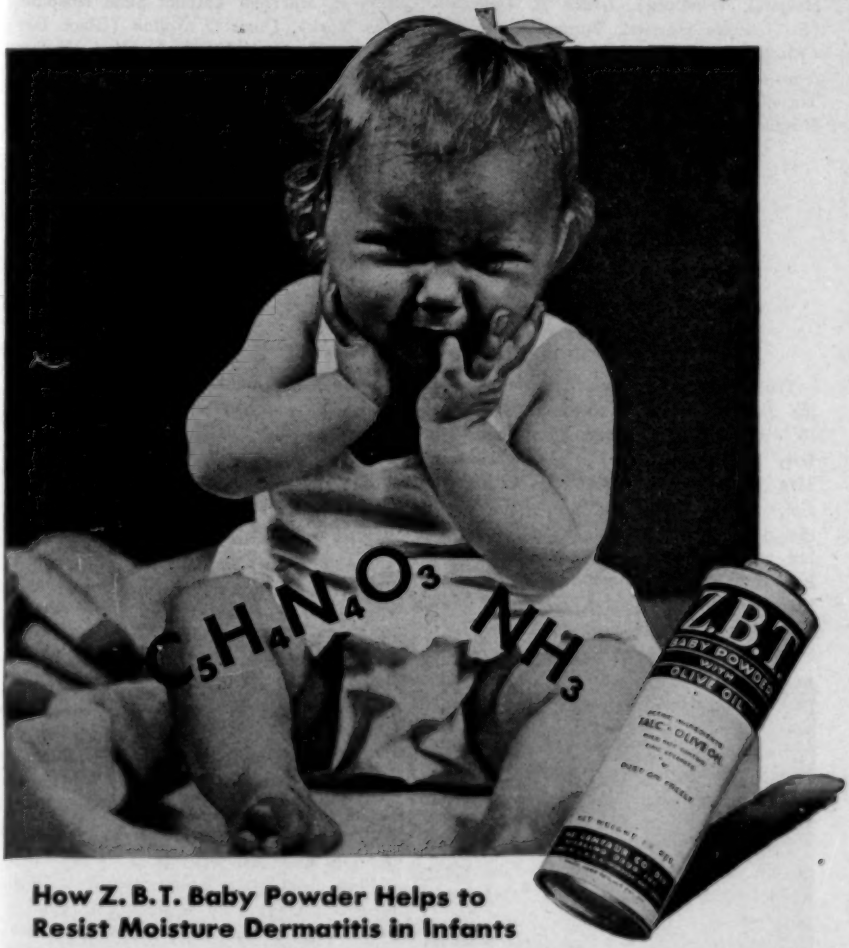
The following members of the R.C.A.M.C. Nursing Service received awards in the King's New Year's Honour List:

*M.B.E.*: Lt. (N/S) *Norah D. Hughes* (Alberta).

*R.R.C.*: Lt. (N/S) *Henriette Matte* (St. Sacrement Hospital, Quebec City); Lt. (N/S) *Alice M. Nicholson* (Winnipeg General Hospital); Maj. (P/M) *Edith M. Read* (Brantford General Hospital); Maj. (P/M) *Alice C. Tavener* (Wellesley Hospital, Toronto); Capt. (Matron) *Constance J. Winter* (Royal Victoria Hospital, Montreal); Capt. (Matron) *Hilda F. Carson, Jean L. Clemens, Margaret Dewar, Isabella M. Fairfield, Dorothy M. Percy* (all graduates of Toronto General Hospital).

*A.R.R.C.*: Lt. (N/S) *Margaret Baldwin, Meran E. Gemmel* (graduates of Winnipeg General Hospital), Capt. (Matron) *Viola Allan* (Brockville General Hospital), *Elizabeth (Jackson) Alton* (Toronto East General Hospital), Lt. (N/S) *Ivy F. Acworth* (Women's College Hospital, Toronto),

# What is "Acid-Moisture"?




## How Z. B. T. Baby Powder Helps to Resist Moisture Dermatitis in Infants

Dermatitis in infants brought about by wet diapers, clothes and bed clothes is a common and troublesome condition. Because of it the busy physician is often faced with questions from anxious mothers. While normally acid because of uric acid content ($C_5H_4N_4O_3$), urine is sometimes converted into an alkaline irritant in the "ammoniacal diaper" by urea-formed ammonia ($NH_3$).

On the basis of simple mechanical protection, the use of Z.B.T. Baby Powder with olive oil helps to resist moisture dermatitis. Z.B.T. clings and covers like a protective film—lessens friction and chafing of wet diapers and shirts. The mechanical moisture-resisting property of Z.B.T. may be clearly demonstrated. Smooth Z.B.T. on the back of your hand. Sprinkle with water or other liquid of higher or lower pH. Notice how Z.B.T. Baby Powder keeps skin dry as the drops roll off. Compare with any other baby powder.

**Z. B. T.—the only baby powder made with olive oil**

*Anita Borland* (Notre Dame Hospital, Montreal), *Violet B. Cockerill* (Misericordia Hospital, Winnipeg), *Grace E. Cowieson* (St. Joseph's Hospital, Toronto), *Anne E. Cromwell* (Montreal General Hospital), *Nora I. Crozier* (Hospital for Sick Children, Toronto), *Lily M. Dalgleish* (St. Michael's Hospital, Toronto), *Marjorie T. Dolan* (St. Vincent de Paul Hospital, Brockville), *Rachel Lachance* (Ottawa General Hospital), *Mary E. MacIsaac* (Mount Sinai Hospital, New York), *Doris D. Salton* (Glace Bay General Hospital, N.S.), *Hazel I. Ussher* (Wellesley Hospital, Toronto), Act. Capt. (Matron), *Evelyn C. Chesham* (Royal Victoria Hospital, Montreal).

## Nursing Sisters' Association of Canada

The annual Remembrance Day dinner of the *Toronto Unit* was held on November 10, with 225 sisters in attendance, including fifty of World War II. The president, Mrs. Gilbert Storey, received the guests. Col. Agnes Neill, Matron-in-Chief, was the guest speaker, who gave a resumé of her visits to the Canadian hospitals in Italy and elsewhere on the Continent. Col. Elizabeth Smellie was also present and spoke on her activities as former Matron-in-Chief. Seated at the head table with the president were: Col. Neill, Col. Smellie, P/M Annie Boyd (Camp Borden), P/M Mary Shaffner (Chorley Park), Matron Elizabeth Russel and Matron Nigon (London), Pearl Morrison, Isobel McEwen, and Mrs. Henson. This successful event was convened by Mrs. Jack Bell and her committee.

The Toronto Unit is organizing a group to join the Blue Cross Hospital Plan sponsored by the Ontario Hospital Service Association.

At the Remembrance Day dinner held by the *Montreal Unit* 148 nursing sisters were present, including 93 who served in World War II. The guest speaker was Capt. David Legate, former deputy overseas commissioner of the Canadian Red Cross. Other guests at the head table included the president, Gwen Holland, Mrs. Legate, Dorothy MacRae, who is now taking a course at McGill University, Matron Henderson, of Queen Mary Military Hospital and Rev. Capt. Stuart who served overseas. At the Remembrance Day service the president placed a wreath on the Cenotaph.

The Unit has contributed $450 and donated five hundred knitted woollen articles to the British Minesweepers Auxiliary. Mrs. Lydia (Acheson) Routh is chairman of the committee working with this auxiliary. Mrs. Stuart Ramsay has been appointed provincial superintendent, Montreal Corps, St. John Ambulance Association.

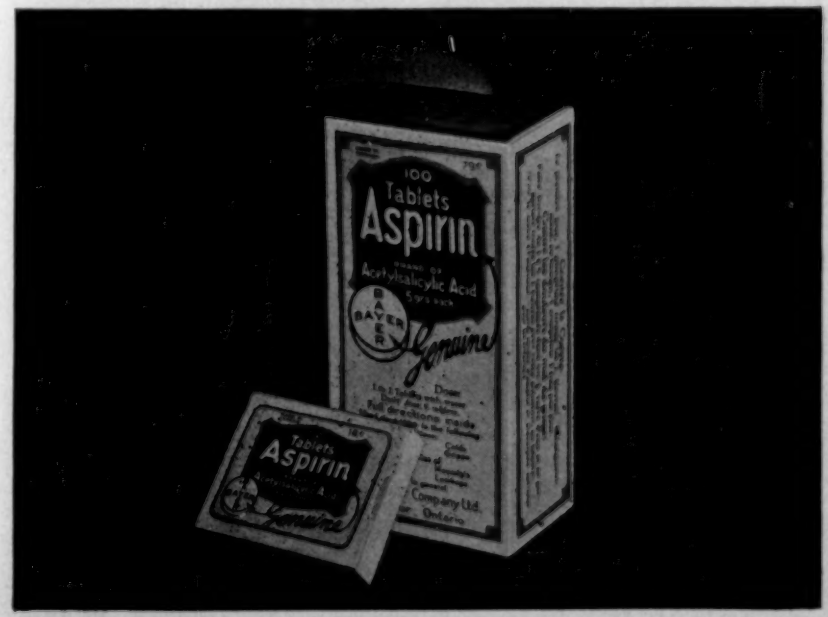
The *Ottawa Unit* recently held their fourteenth annual meeting with the president, Mrs. Spalding, in the chair. The twenty-five members present heard Mrs. W. MacDermott, the guest speaker, tell of her experiences and observation while on an inspection tour in connection with the Red Cross in England. Capt. St. George of the headquarters staff, and Mrs. Hogarth, formerly of Victoria, were welcomed as new members.

The *Regina Unit* reports that they have twenty-one members in good standing. Five meetings were held last year at the homes of various members, refreshments and a social hour concluding each session. This Unit is affiliated with the Navy League and their representative, Mrs. Harradane, reported that fifty-six knitted articles had been handed in. Assistance was given at Blood Donor Clinics and once a month members were responsible for canteen and entertainment services at the Hostess Club. The Vesper Services were attended in May and a spray was placed on the Cross of Sacrifice in June. On Remembrance Day a wreath was placed on the Cenotaph.

Mrs. Broughton has left Regina to reside in Prince Albert and Mrs. Leville and Miss Hudson have returned. Mrs. Shand is now in Halifax with her husband.

The forty-seven years of successful use of Aspirin have proved its great safety and effectiveness. Literally millions of people, in all walks of life, have taken Aspirin daily for the relief of simple headache, neuralgia, and neuritic pains without ill effects. No wonder Aspirin is generally considered to be one of the safest — probably the safest—of all analgesic drugs.

# ASPIRIN



# Priority FOR Baby

At present, there is a shortage of Baby's Own Soap. Therefore, we are asking all those, who use or recommend it, to save Baby's Own Soap for Baby. 75 years of scientific research and close adherence to the recommendations of dermatologists and general practitioners have combined to make Baby's Own Soap the purest and gentlest available for any baby's tender skin. The same strict laboratory control, meticulous care in the choice of ingredients, and careful manufacture of Baby's Own Oil and Baby's Own Powder is your assurance that these also, can be recommended with complete confidence.

**Baby's Own** *Toiletries*

**SOAP — OIL — POWDER**

***FOR THE CARE OF THE BABY***


## Ontario
## Public Health Nursing Service

*Jennie Berry* (Kingston General Hospital and University of Western Ontario public health course), who has recently been discharged from the R.C.A.M.C., has accepted an appointment with the Brant County Health Unit. *Jean Stewart* (University of Toronto School of Nursing diploma course) has accepted a position with the East York Board of Health. *Dorothy Adams* (Winnipeg General Hospital and University of Toronto public health course), who has recently been released from service with the R.C.A.M.C., has been appointed to the staff of the Windsor Board of Health. *Margaret Phillips* (University of Ottawa School of Nursing and McGill University public health course), recently returned from service with the R.C. A. M. C., has accepted a position with the Ottawa Board of Health.

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# NEWS NOTES

### ALBERTA

EDMONTON:

The annual meeting of Edmonton District, No. 7, A.A.R.N., was recently held with seventy-five members present. Mrs. V. Pearson was in the chair. The election of officers took place with the result that Madeline McCulla is the new chairman; R. Ball and Sr. St. Valerie, vice-chairmen, J. Boyd, recording secretary, A. Lysne, treasurer, and Mrs. A. MacKay is registrar. A concert is to be sponsored for the purpose of raising funds. It was announced that the A.A.R.N. annual meeting will be held in April at the Macdonald Hotel.

*Edmonton General Hospital*:

The annual banquet of the Edmonton General Hospital Alumnae Association, which was opened by the superior, Rev. Sister O'Grady, was held recently with seventy members present. Seated at the head table were Mrs. R. Price, president; E. Beitsch, chairman; Mmes J. Loney, W. McCready,

vice-presidents; Mrs. E. Barnes, recording secretary; L. Singer, corresponding secretary; Mrs. E. Cunnings, treasurer; standing committee, Mmes H. Southgate (convener), J. Hope, C. Johnston, J. Kerr, Miss G. Hochhausen. E. Matthewson was the guest for the evening.

Mrs. Price proposed the toast to the King and Mrs. McCready the toast to the training school. The superintendent of nurses, Rev. Sister Keegan, made the draw for the raffle, "The Princess Margaret Rose Tea Set" being won by Miss McCarthy. Musical selections included a violin solo by Marjory Kruk and vocal selections by R. Ravnsborg, T. Bourne, K. Kelly, M. Potvin, J. Halvorson, and V. Hanson, accompanied by G. Wettre at the piano.

*Royal Alexandra Hospital*:

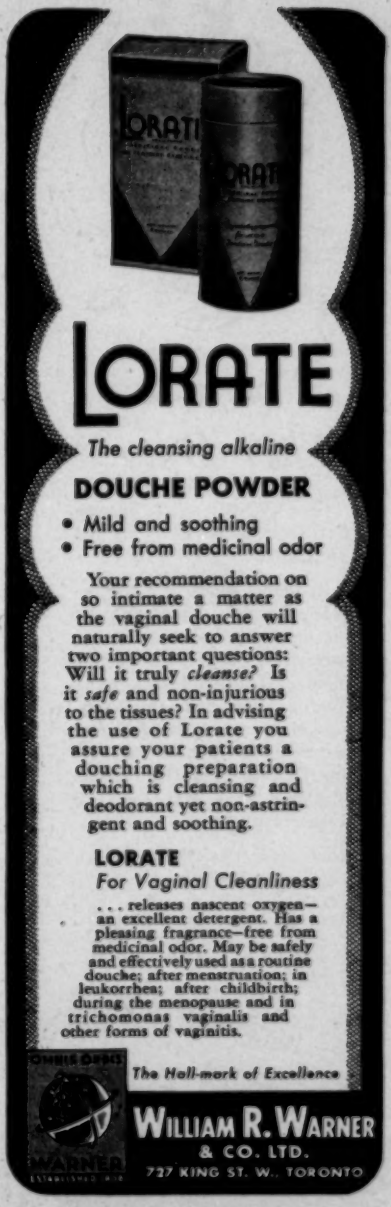
The Royal Alexandra Hospital Alumnae Association recently held its annual meeting with Violet Chapman in the chair. Reports were given by all officers concerning the activities of the alumnae during 1945. It was agreed that a "Blue Book" should be published containing the names and addresses of all graduates of the school. The committee appointed for this project is composed of Mmes N. Richardson, T. Blacklock, and A. Boutillier. The election of officers took place with the result that Miss Chapman was re-elected president. The vice-presidents are Mrs. N. Richardson and A. Lord; treasurer, D. Watt; recording secretary, H. Adams; and corresponding secretary is O. Podborski.

At a later meeting, forty-two members were privileged to hear Emily Mayhew tell of her experiences in South Africa where she went with the first group of eighty Canadian nurses early in 1941. She also gave us a grapic description of her work on the hospital ship, *Lady Nelson*, where she nursed for six months. M. Fraser thanked the speaker. The president was in the chair.

## BRITISH COLUMBIA

TRAIL:

The annual meeting of Trail Chapter, R.N.A.B.C., was held recently when the election of officers took place with the result that Mrs. K. Gordon is president, Mrs. E. Kinahan, vice-president, B. Kirkpatrick, secretary, and M. White is treasurer. Final plans were made for the annual ball.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## MANITOBA

BRANDON:

At a recent meeting of the Brandon Graduate Nurses Association plans were made to raise the annual scholarship of $350 for post-graduate study. A hearty response is welcomed from the Brandon General Hospital Medical Faculty and the service clubs of the community. Through the combined effort in reaching the objective, it is hoped an interest will be created in post-graduate work. The scolarship committee is convened by a scholarship student.

## NEW BRUNSWICK

ST. STEPHEN:

At the first meeting of the St. Stephen Chapter, N.B.A.R.N., held this year the new president, Mabel McMullen, was in charge when routine business was transacted. A drive is now underway for more subscriptions to *The Canadian Nurse*.

*Chipman Memorial Hospital*:

At a recent meeting of the Chipman Memorial Hospital Alumnae Association it was decided to send a box of food and other articles to a Dutch nurse every other month alternating with the local chapter. It was voted to spend $50 on extra furnishings for the alumnae room in the maternity wing of the hospital. Dr. G. G. Hatfield of the Department of Public Health, Charlotte County, gave an informative talk on "Psychiatry", stressing the need for psychiatric nursing in everyday work.

R. E. Follis, superintendent, and nursing staff of the C.M.H. recently entertained with a tea and miscellaneous shower for Marguerite Langmaid.

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## ONTARIO

*Editor's Note*: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

DISTRICT 4

WELLAND:

The Graduate Nurses Association reports that their Christmas party was well attended

when carols were sung and games played. After the gifts were distributed a luncheon was served. At the short business meeting held later $5 was donated to the Welland Sea Cadets.

The annual election of officers resulted as follows: honourary president, A. Oram; president, Mrs. C. Hill; vice-president, Miss Miller; secretary, K. Maddaford; treasurer, Miss Kingersley. Conveners and committees were chosen to look after gifts, flowers, entertainment, and membership. Mmes H. Beatty and J. Reuter are to purchase and pack a box of food for nurses in the Netherlands.

## District 5

### Toronto:

*Women's College Hospital:*

At a recent meeting of the Women's College Hospital Alumnae Association Dorothy Macham, A.R.R.C., newly-appointed superintendent of the hospital, was given a hearty welcome. Miss Macham has recently returned from overseas after five and a half years of service with the R.C.A.M.C.

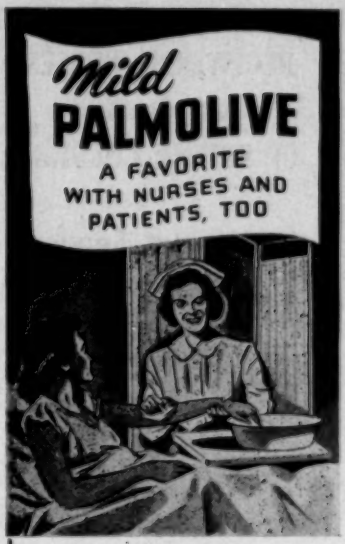
Dorothy MacGregor, for a number of years with the Red Cross out-posts in Ontario, is head nurse in the O.P.D. Thora Hawkes is now head nurse in the admitting dept. G. Ament recently returned from India where she has been with missionary schools since 1922.

The following nursing sisters have recently returned from service overseas: Phyllis Storer, Bertha Perry, Rhea Raycroft, Ann Topping, Mrs. A. (Ackworth) Faeth, recently awarded the A.R.R.C.; Ethel MacKenzie, on the operating-room staff, Port Arthur General Hospital; A. Hastings, on staff at Christie St. Hospital. Catherine MacLean has recently been discharged from the R.C.A.F.

## District 7

### Kingston:

Over one hundred members and guests were present at the recent annual meeting of District 7, R.N.A.O., which was held at the General Hospital, with the chairman, Mrs. Irma Laskin, presiding. Dr. W. F. Connell was the guest speaker and his interesting lecture on "Nursing in Diseases of the Heart" was most instructive. It was revealed

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Information regarding positions for Registered Nurses in the Province of British Columbia may be obtained by writing to:

**Elizabeth Braund, R.N., Director Placement Service**

**1001 Vancouver Block, Vancouver, B.C.**

**REGISTRATION OF NURSES**
**Province of Ontario**

EXAMINATION ANNOUNCEMENT

An examination for the Registration of Nurses in the Province of Ontario will be held on May 29, 30, and 31.

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

**EDITH R. DICK, Reg. N.**

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that a parcel a month is being forwarded to two Dutch nurses for whom the District has assumed responsibility. It has been decided to pay an honorarium of $25 annually to the secretary-treasurer for her services. The expenses of delegates to future board meetings are to be paid by the R.N.A.O. The chairman was chosen as the delegate to represent the District at the C.N.A. Biennial Convention.

Reports from the various conveners were presented as follows: Membership—Marjorie Quigley reported there were 442 members for 1945. Finances—The secretary-treasurer revealed that there was a balance of approximately $206.73 plus War Savings Certificates to the value of $125. Publications—Report given by Mrs. Kathleen Burke. Hospital and school of nursing section—L. D. Acton stressed the benifit student nurses of the District are receiving from the pyschiatric affiliation at the Ontario Hospital, Kingston. General nursing section—Mrs. Laskin said the great majority of calls for private duty nurses had been filled satisfactorily. Public health nursing section—G. Conley reviewed the work of the Department of Public Health for the District. Margaret Coldrey gave the Kingston Chapter report and the Brockville and Perth reports were read by the secretary-treasurer. D. Morgan reviewed the activities of the permanent education fund.

### District 8

*Ottawa General Hospital*:

R. MacDonald is taking the course in clinical supervision at the University of Toronto while A. Soulière is at the McGill School for Graduate Nurses for the public health course. Mona Belier has accepted a position with the Children's Aid Society, Betty Poulin with the Ottawa Health Department, and Florence Lepine with Canada Packers, Hull.

### QUEBEC

MONTREAL:

*Children's Memorial Hospital*:

B. O. MacInnes was re-elected president of the Staff Nurses' Association, Children's Memorial Hospital, at the recent annual meeting. V. Siddall is vice-president, M.

MacDougall, secretary, and H. Marshall is treasurer.

Margaret Kerr, editor of *The Canadian Nurse*, gave an interesting talk on "Sex Education" at a recent meeting, with members of the post-graduate group and student body present.

Gladys Stevens (N.S. Hospital, Dartmouth) has been appointed to the operating-room staff. Ann Lesink and Donalda Clark (St. Joseph's Hospital, Victoriá) are now with the newly-opened out-patient department. Miss Nakano has resigned to be married and will reside in Saskatchewan. Ex-staff members who have been visitors recently are Ray Wilson, Laura Gray, Mary Rogers, Mary Ernshaw, and Gareth Forgrave, recently discharged from the Navy, and en route to British Columbia.

*Montreal General Hospital*:

At the recent annual meeting of the Montreal General Hospital Alumnae Association the following officers were elected: honourary president, J. Webster; president, M. Shannon; vice-presidents, M. Batson, A. Peverley; recording secretary, K. Clifford; corresponding secretary, A. Christie; honorary treasurer, I. Davies. The monthly Sunday teas are as popular as ever. The one held in January was in aid of the "Save the Children Fund" when approximately a hundred and fifty guests attended.

The following recent graduates are on the nursing staff of the Central Division: Helen Gagnon, Stella Gove, Madge Coons and Mary Critchley. Bernice Legere has resigned from the out-patient staff and is now with the infirmary at the T. Eaton Co., Montreal.

*Royal Victoria Hospital*:

Capt. (Matron) Connie J. Winter, R.C.A.M.C., was recently awarded the R.R.C. Margaret Pringle is now superintendent of the J. H. Dunn Hospital, Bathurst, N.B. Margaret Street is ward instructor, Ross Memorial. Margaret Smith recently returned as assistant supervisor, Ross Memorial. Pauline Jones is in charge of a ward in the Col. Newburn Pavilion, University of Alberta Hospital. Helen Davidson is on the obstetrical ward, Peterborough Civic Hospital. Grace Stevens, recently discharged from the R.C.A.M.C., is doing post-graduate work in the operating-room.

*St. Mary's Hospital*:

The annual card-party of St. Mary's

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**ANATOMY and PHYSIOLOGY**

**By F. T. Jung, Anna Benjamin, and Elizabeth C. Earle.** Based on the **Unit Plan** of organization, according to **systems,** this text presents the pertinent facts concerning the structure and activities of the human body required for a complete course in anatomy and physiology. 666 pages. 367 illustrations. $4.40.

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**TORONTO**

Hospital Alumnae Association was held recently when Mrs. W. Johnson, the president, received the guests. The following nurses helped in serving refreshments and distributing prizes: E. O'Hare, M. Smith, M. MacDonald, D. Sullivan, M. Barrett, A. Marwan, R. Cook, M. Collins, E. Toner, E. Ryan, Mmes J. Leu and G. Higden. Dorothy Sullivan was the able convener.

Among the nursing sisters recently returned from overseas are K. Brady, R. Megin, L. Shea, B. Reddy, M. Healey, Mmes N. Guadagni and V. Gerby. Mary Morrow has received her discharge from the R.C.A.M.C. and is now enrolled in the Faculty of Science, McGill University. Dominica Sullivan is doing V.O.N. nursing. Alyce McKenna is now supervisor, 2nd floor surgery.

Drs. Magnus Seng and G. T. Altimas have been recent guest speakers at alumnae meetings.

QUEBEC CITY:

At a recent meeting of Jeffery Hale's Hospital Alumnae Association it was decided to send boxes of food to Dutch nurses while the need is so urgent. At a further meeting Dr. R. C. Hastings gave a most interesting talk on his trip to the Eskimos on the government boat, *The MacLean.* He told of the Eskimo way of life, describing their lack of religion and medical care. In his address he revealed what an intelligent race they really are and later displayed several specimens of Eskimo implements and handicraft. The speaker was introduced by Mrs. Macalister and thanked by Mrs. Pfeiffer.

A. MacDonald and M. Jones have left the J.H.H. staff and are now with the University Hospital, Edmonton. I. Matthew, formerly with the South African Nursing Service, is back on the J.H.H. staff. N/Ss M. Doddridge, J. Warren, and P. Levie, who have all seen active service overseas, are on the staff of the Quebec Military Hospital. Mrs. A. T. Walker, who served with the South African Nursing Service, is now with her husband in England. M. L. Eager, formerly with the S.A. Nursing Service and R.C.A.M.C. overseas, has received her discharge. Mrs. J. Quail, who was overseas with the R.C.A.M.C., is now living in Toronto.

The result of the election of officers was as follows: president, M. G. Fischer; vice-presidents, Mmes A. MacDonald, C. Kennedy; secretary, Mrs. J. Green; treasurer, Mrs. W. Pfeiffer; councillors, Mmes Macalister, Young.

Miss N. Humphries, *Canadian Nurse* representative, requests that all J.H.H. graduates living outside Quebec City forward to her at the hospital any interesting items concerning former alumnae..

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SASKATCHEWAN

HUMBOLT:

The Humboldt Chapter entertained the student nurses of St. Elizabeth's Hospital at a Christmas concert, At a recent meeting a film, entitled "Otoscopy on the Inflammation of the Ear", was shown.

PRINCE ALBERT:

Prior to her marriage, Mrs. Frank (Gies) Chad was entertained at a shower at the Holy Family Hospital, where she is a mem-

ber of the staff. A shower was also held for Ione Rooney, staff member, Holy Family Hospital, by N. Lambert, instructress.

REGINA:

Mrs. D. G. Creara and Col. Agnes Neill, Matron-in-Chief, R.C.A.M.C., on her first official visit to Western Canada, were entertained at tea in the Nursing Sisters Officers Mess. Grace Giles, travelling instructor, S.R.N.A., recently visited both Regina hospitals.

S. Lefebvre and M. Poisson are now on the staff at the Grey Nuns' Hospital. H. Lusted has resigned from the Regina Branch, V.O. N., to take up new duties at the National Office of the Order. Helen Bradley, recently discharged from the R.C.A.M.C., is now on the staff of the General Hospital.

WEYBURN:

Misses Cassidy and Vandendriessche, formerly on the staff of the Weyburn General Hospital, recently spent a short while at their homes here. Ruth Hicks, of LaJolla, Calif., recently, visited at the home of Mrs. H. E. Mitchell. Miss Hicks was the first superintendent of the General Hospital.

The Weyburn Chapter reports that a letter of good wishes was sent to young women entering schools of nursing from Weyburn.

YORKTON:

The Yorkton Chapter, District 4, S.R.N.A., elected the following officers at its first meeting of the year: president, Mrs. L. Logan; vice-president, Mrs. E. Sinclair; secretary, Mrs. L. Wynn; treasurer, K. Francis; A. Gwilliam, Mrs. A. Hamilton. Chairmen of sections: General nursing, Mrs. V. Young; hospital and school of nursing, V. Ostapovich; public health, J. Clark.

A project of interest to the Yorkton Chapter for the coming months will be a study and talks on "Nursing in Other Countries". K. Francis and Mrs. Rouse will begin the series with "Nursing in England."

Vera Ostapovich, former supervisor of the obstetrical dept. of the General Hospital, has returned and is now assistant superintendent. For the past year Miss Ostapovich has been at the Toronto General Hospital.

A time-proven reliable relieving aid for infant's simple constipation, teething fevers, stomach upsets. A boon to mothers and nurses as an evacuant in the digestive disturbances which often accompany teething or which sometimes follow a change of food, where prompt yet gentle elimination is desirable. Sympathetic to baby's delicate system. No opiates of any kind. Over 40 years of ever-increasing use speak highly for their effectiveness.

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**Supt. of Nurses, Jewish General Hospital, 3755 St. Catherine Rd., Montreal 26, P. Q.**

## WANTED

**Vancouver General Hospital** desires applications from Registered Nurses for **General Duty.** State in first letter date of graduation, experience, references, etc., and when services would be available.

Eight-hour day and six-day week. **Salary: $95 per month living out, plus** $19.92 Cost of Living Bonus, plus laundry. One and one-half days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. One month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to:

**Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital Vancouver, B. C.**

## WANTED

**A class room Instructress** for a 120-bed hospital. Apply stating qualifications, experience and salary expected, to:

**The Superintendent, Stratford General Hospital, Stratford, Ont.**

## WANTED

An **Operating Room Supervisor,** with post-graduate experience, is required. Apply, stating qualifications, experience, and salary expected, to:

**Supt., Victoria Public Hospital, Fredericton, N. B.**

## WANTED

A **Supervisor** is required for a 64-bed General Hospital. State experience and salary expected. Apply to:

**Supt., Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.**

## WANTED

A qualified **Instructress,** to take charge of Teaching Department and teach the Science subjects, is required by **August 1, 1946.** Apply to:

**Director of Nursing, Saskatoon City Hospital, Saskatoon, Sask.**

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Applications are invited for the following positions in a 170-bed hospital in the Maritime Provinces, with attractive salaries and maintenance: **Night Obstetrical Supervisor; Superintendent of Nurses; Instructress of Nurses; Supervisor,** experienced and qualified, for private floor, days; **Dietitian,** experienced and qualified. Apply in care of:

**Box 4, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.**

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Applications are invited for the position of **Provincial District Nurse** in the **Province of Alberta.** Districts located in rural areas; cottage, water and fuel supplied by community. **Salary:** Minimum of $1500 per annum plus Cost of Living Bonus. Sick leave; annual vacation provided after one year's service. Information also provided on other Public Health Nursing opportunities in the Province. Apply to:

**Miss Helen G. McArthur, Supt. of Nurses, Dept. of Public Health, 218 Administration Bldg., Edmonton, Alta.**

## WANTED

Applications are invited for the position of **Science Instructor** at the **University of Alberta School of Nursing.** Duties to commence on or after **June 1, 1946.** Applicant to have University degree. Apply, stating qualifications, experience, etc., to:

**Director, School of Nursing, University of Alberta, Edmonton, Alta.**

## WANTED

**General Duty nurses** (one with special Obstetrical training) are required at a salary of $100 per month. **Operating Room Supervisor** is also required at a salary of $105 per month, plus full maintenance less tax. Apply, stating qualifications, to:

**Superintendent, St. Paul's Hospital, Hearst, Ont.**

## WANTED

A Graduate nurse, with Operating Room experience, is required for the **Barrie Memorial Hospital.** Apply to:

**Superintendent, Barrie Memorial Hospital, Ormstown, P. Q.**

## WANTED

**Ontario Hospital, Kingston,** requires Registered Nurses for **General Duty.** State date of graduation and references in first letter. 8-hour day and 6-day week. **Salary:** $1300 per annum. Living out. Superannuation. 3 weeks' annual vacation with pay. Public holidays or equivalent time with pay. One and one-half days' sick leave per month, accumulative, with pay. Apply to:

**Supt. of Nurses, Ontario Hospital, Kingston, Ont.**

## WANTED

Applications are invited for the positions of qualified **Operating Room Supervisor, Obstetrical Supervisor, Night Supervisor,** and **General Duty** nurses in a 75-bed hospital. Apply in care of:

**Box 3, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.**

## WANTED

**A Superintendent of Nurses** is required for a 120-bed Public Hospital with Training School. Duties are to commence on **May 1.** Apply, with photograph, giving full particulars in first letter of qualifications, experience, necessary personal information (age, etc.), and salary expected to:

**Secretary-Treasurer, Board of Management, Galt Hospital, Lethbridge, Alta.**

# Official Directory

## THE CANADIAN NURSES ASSOCIATION

1411 Crescent St., Montreal 25, P. Q.

**President** ..... Miss Fanny Munroe, Royal Victoria Hospital, Montreal 2, P. Q.
**Past President** ..... Miss Marion Lindeburgh, 3466 University Street, Montreal 2, P. Q.
**First Vice-President** ..... Miss Rae Chittick, Normal School, Calgary, Alta.
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**Honourary Secretary** ..... Miss Evelyn Mallory, University of British Columbia, Vancouver, B. C.
**Honourary Treasurer** ..... Miss Marjorie Jenkins, Children's Hospital, Halifax, N. S.

### COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

*Numerals indicate office held: (1) President, Provincial Nurses Association; (2) Chairman, Hospital and School of Nursing Section; (3) Chairman, Public Health Section; (4) Chairman, General Nursing Section.*

**Alberta:** (1) Miss B. A. Beattie, Provincial Mental Hospital, Ponoka; (2) Miss B. J. von Gruenigen, Calgary General Hospital; (3) Mrs. R. Sellhorn, V.O.N., Edmonton; (4) Miss M. A. Franko, 9653-103a Ave., Edmonton.

**British Columbia:** (1) Miss E. Mallory, 1088 W. 19th Ave., Vancouver; (2) Miss E. Nelson, Vancouver General Hospital; (3) Miss T. Hunter, 4238 W. 11th Ave., Vancouver; (4) Miss E. Otterbine, 1334 Nicola St., Ste. 5, Vancouver.

**Manitoba:** (1) Miss L. E. Pettigrew, Winnipeg General Hospital; (2) Miss B. Seeman, Winnipeg General Hospital; (3) Miss H. Miller, 728 Jessie Ave., Winnipeg; (4) Mrs. J. MacTavish, 8 Willingdon Apts., Winnipeg.

**New Brunswick:** (1) Miss M. Myers, Saint John General Hospital; (2) Miss M. Murdoch, Saint John General Hospital; (3) Miss M. Hunter, Dept. of Health, Fredericton; (4) Mrs. M. O'Neal, 170 Douglas Ave., Saint John.

**Nova Scotia:** (1) Miss R. MacDonald, City of Sydney Hospital; (2) Sister Catherine Gerard, Halifax Infirmary; (3) Miss M. Ross, V.O.N., Pictou; (4) Miss M. MacPhail, 29 St. Peter's Rd., Sydney.

**Ontario:** (1) Miss Jean I. Masten, Hospital for Sick Children, Toronto; (2) Miss E. Young, Peterborough Civic Hospital; (3) Miss S. Wallace, Division of Industrial Hygiene, Parliament Bldgs., Toronto 2; (4) Miss K. Layton, 341 Sherbourne St., Toronto 2.

**Prince Edward Island:** (1) Miss D. Cox, 101 Weymouth St., Charlottetown; (2) Sr. M. Irene, Charlottetown Hospital; (3) Miss S. Newson, Junior Red Cross, Charlottetown; (4) Miss M. Lannigan, Charlottetown Hospital.

**Quebec:** Miss E. Flanagan, 3801 University St., Montreal 2; (2) Rev. Sr. Denise Lefebvre, Institut Marguerite d'Youville, 1185 St. Mathews St., Montreal 25; (3) Miss A. Girard, l'Ecole d'infirmières hygiénistes, University of Montreal, 2900 Mt. Royal Blvd., Montreal 26; (4) Miss E. Killins, 1230 Bishop St., Montreal 25.

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**Chairmen, National Sections:** Hospital and School of Nursing: Miss Martha Batson, Montreal General Hospital. Public Health: Miss Helen McArthur, 218 Administration Bldg., Edmonton, Alta. General Nursing: Miss Pearl Brownell, 212 Balmoral St., Winnipeg, Man. Convener, Committee on Nursing Education: Miss F. K. Russell, 7 Queen's Park, Toronto 5, Ont.

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*New Brunswick Ass'n of Registered Nurses:* Miss Alma F. Law, 29 Wellington Row, Saint John.

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*Registered Nurses Ass'n of Ontario:* Miss Matilda E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5.

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*Saskatchewan Registered Nurses Ass'n:* Miss Kathleen W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

# Provincial Associations of Registered Nurses

## ALBERTA

### Alberta Association of Registered Nurses

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### Ponoka District, No. 2, A.A.R.N.

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### Calgary District, No. 3, A.A.R.N.

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### Medicine Hat District, No. 4, A.A.R.N.

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## BRITISH COLUMBIA

### Registered Nurses Association of British Columbia

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### Manitoba Association of Registered Nurses

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**Registered Nurses Association of Ontario**

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## PRINCE EDWARD ISLAND

**Prince Edward Island Registered Nurses Association**

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## QUEBEC

**Registered Nurses Association of the Province of Quebec (Incorporated 1920)**

Pres., Miss E. C. Flanagan; Vice-Pres. (*English*), Miss M. S. Mathewson; Vice-Pres. (*French*), Rev. Soeur Valérie de la Sagesse; Hon. Sec., Miss E. B. Cooke; Hon. Treas., Mlle A. Martineau; *Members without Office*; Misses M. K. Holt, V. Graham, A. Peverley, Rev. Sr. M. Flavian, Rev. Soeur J. M. Décary, Mlles M. Roy, J. Lamothe (Three Rivers), M. Taschereau (Quebec), A. M. Robert; *Advisory Board*: Misses C. M. Ferguson, G. M. Hall, M. L. Moag, F. Munroe, Mlles M. Beaumier (Quebec), J. Trudel, L. Taschereau; *Conveners of Sections: Hospital & School of Nursing (English)*, Miss D. Parry, Children's Memorial Hospital, Montreal 25; (*French*), Rev. Soeur D. Lefebvre, Institut Marguerite d'Youville, Montréal; *Public Health (English)*, Miss M. Trueman, 1648 Sherbrooke St. W., Montreal; (*French*), Mlle A. Girard, Ecole d'Infirmières Hygiénistes, Université de Montréal; *General Nursing (English)*, Miss E. Killins, 3533 University St., Montreal; (*French*), Mlle A. M. Robert, 3677 rue St. Famille, App. 28, Montréal; *Boards of Examiners*: (*English*), Miss M. S. Mathewson (chairman), Misses M. Flander, E. Allder, K. Stanton, Mrs. S. Townsend, C. Aitkenhead; (*French*), Rev. Soeur M. C. Rheault (chairman), Revs. Soeurs Paul du Sacré-Coeur, Marcellin, J. de Lorraine, Mlles J. Trudel, M. Beaumier; Executive Secretary, Registrar & Official School Visitor, Miss E. Frances Upton, 1012 Medical Arts Bldg., Montreal 25. *Chairmen District Associations*: 1—Mlle M. A. Chamard, New Carlisle, Cté Bonaventure; 2—Rev. Soeur M. Madeleine Hôtel-Dieu Lévis; 3—*English* Chapter, Mrs. L. S. Lothrop, 85 London St., Sherbrooke; *French* Chapter, Mlle J. Dupuis, Hôpital Général St. Vincent de Paul, Sherbrooke; 4—Mlle L. Ménard, Hôpital St. Charles, St. Hyacinthe; 5—Mlle M. Beauregard, 228 rue Collin, St. Jean; 6—Rev. Soeur Ste. Rose, Hôpital d'Youville, Noranda; 7—Mlle L. Robert, Hôpital St. Eusèbe, Joliette; 8—Mlle A. Benoît, 727 rue Ste. Cécile, Shawinigan Falls; 9—*English* Chapter, Miss M. Lunam, Jeffery Hale's Hospital, Quebec; *French* Chapter, Rev. Soeur M. St. Paul, Hôpital St. François d'Assise, Québec; 10—Mlle D. Grimard, 59 ave Ste. Anne, Chicoutimi; 11—*English* Chapter, Miss M. Lewis Brown, Lachine General Hospital; *French* Chapter, Rev. Soeur Filion, Hôpital Pasteur, Montréal; 12—*English* Chapter, Miss C. V. Barrett, Royal Victoria Montreal Maternity Hospital, Montreal; *French* Chapter, Mlle A. Martineau, 1034 rue St. Denis, Montréal.

## SASKATCHEWAN

**Saskatchewan Registered Nurses Association (Incorporated 1917)**

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**A.A., Holy Cross Hospital, Calgary**

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**A.A., University of Alberta Hospital, Edmonton**

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